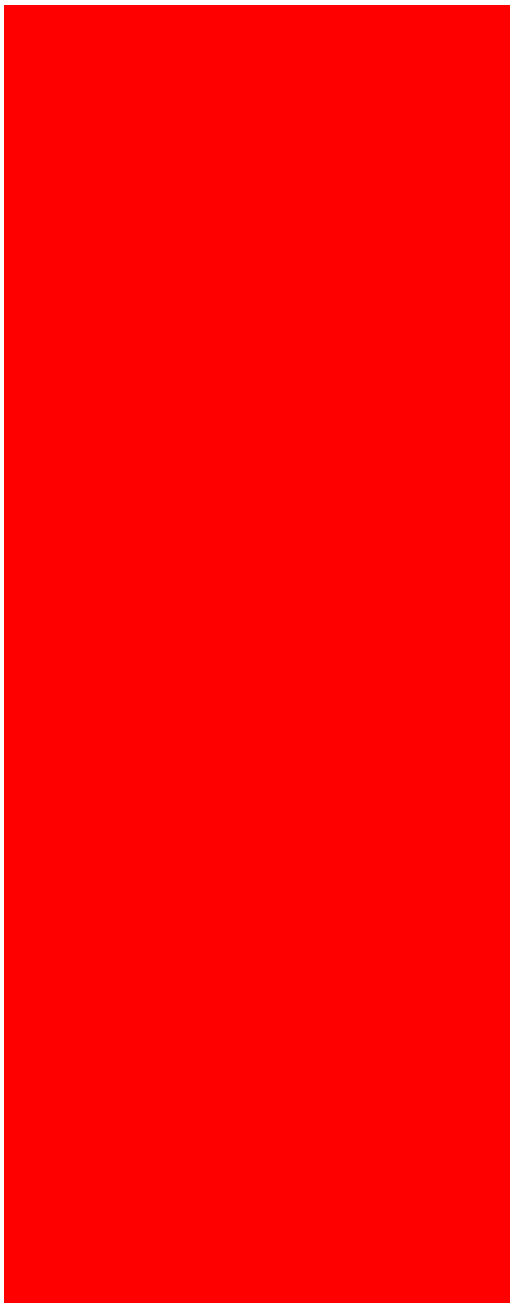
# 113 SECTION Q – CLAIMS MANAGEMENT

114 Q.1



# Section Q: Claims Management (Section §17 of RFP)

**Q.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.**

For over 25 years, Aetna Better Health®'s affiliates have used their expansive expertise in the development and implementation of an IT infrastructure to improve the accessibility and quality of healthcare services for its covered populations, while controlling the program's rate of cost increase. We benefit, in this endeavor, from the strategic alignment of IT resources with Aetna Medicaid, an Aetna Company (Aetna Medicaid). For example, while Aetna Better Health benefits – on one hand – from the backing of Aetna Medicaid's considerable resources in hardware and network infrastructure support, we also count ourselves fortunate – on the other – for the unwavering support of Aetna Medicaid's expertise in application support and configuration management. When combined, these systems bring Aetna Better Health every advantage one could expect from an IT infrastructure that is reliable, flexible, expandable, and designed to interface seamlessly with other systems. In this section, the systems and applications that support the major functional areas of Aetna Better Health are detailed, starting with the guiding principles that form the foundation of our IT infrastructure:

- **Privacy and Security:** To secure members' Protected Health Information (PHI), a layered approach to security includes clearly delineated policies and procedures, employee training, comprehensive communications, hardening of physical systems, adherence to federal laws such as HIPAA and Louisiana specific requirements that are more stringent.
- **Business Integration:** Aetna Better Health's IT systems have the ability to integrate and map data from disparate systems, inside and outside the company, and to utilize data mining tools to analyze and report Key Performance Indicators (KPI) to improve the quality of services.
- **People:** Aetna Better Health shares with Aetna Medicaid the mission of providing "value, integrity and compassion in healthcare management" through recruiting and retaining the most skilled and experienced IT personnel available and continuously training them on the most up-to-date technologies.
- **Business Continuity**: Even the best applications and systems are ineffectual if they are not available. To address this, Aetna Better Health has built redundancy into the IT infrastructure, communication services and environmental support systems. We have a 99.9% system availability record for our computer systems and applications.
- **Scalability:** Aetna Better Health will meet DHH's changing needs by managing the network infrastructure, load-balancing server clusters and communications systems with the ability to grow rapidly without sacrificing availability.

This IT system will support our expansion from GSA A –to GSA B – to GSA C. The depth, reliability, scalability and flexibility of our IT system mean that Aetna Better Health will be able to accept and manage additional membership and providers without interruption or disruption to

our current members and providers. The Aetna Better Health management team and Aetna Medicaid IT team will work together to see that that our expansion activities are seamless and in accordance with our history of excellence in working with Medicaid programs across the nation.

## Provider Payment Support

Aetna Better Health and our affiliates paid 17,761,200 claims nationwide during calendar year 2010. This volume is possible because of our efficient systems, tools and processes.

Aetna Better Health offers our network providers a choice between receiving payment via Electronic Fund Transfer (EFT) or physical checks. The payment method is set to physical check by default, but any network provider wishing to activate EFT need only do the following:

- A network provider submits an EFT enrollment form to Aetna Better Health, indicating the desired bank routing and account numbers
- That information is then loaded into QNXT™, Aetna Better Health's claims payment system, designating that applicant as an EFT network provider
- A test document, called a prenote, is then sent to the network provider's bank to see that the routing and account numbers are accurate and functioning properly
- Upon notification of a successful test transaction, the network provider's account is configured accordingly and EFT enabled
- When the network provider has a payment generated during the check run process, the payment is included in a secure electronic file that is then "held" for submission to the various banks and clearing houses for processing
- Upon approval of the check run by Aetna Better Health, physical checks are released for printing and mailing, while the EFT file is released to the designated financial institutions for processing
- Network providers receiving EFT receive a hard copy remittance via mail detailing the claims processed in a particular payment run, as well as a paper copy of what would have been a check indicating the EFT Check # and total dollars, thereby allowing them to post the payment accordingly

Any network provider wishing to discontinue EFT payments and return to payment by physical check need only contact the health plan in writing and claims personnel will discontinue EFT functionality on the indicated accounts accordingly.

### *Claims Adjudication*

At the heart of Aetna Better Health's claims adjudication process lies QNXT™, a client/server based managed care information system with unmatched claims processing capabilities. Operating in a Microsoft Windows NT™ and SQL Server environment, this rules-based system – with its graphical user interface and relational database – allows users immediate access to real-time claims information. Since QNXT™ is based on a common operating system and database platform, a multitude of tools can be used to display, print and analyze information. Moreover, this information can be presented in both textual and graphical formats to enhance readability and review. The following paragraphs detail Aetna Better Health's claims adjudication processes, our claims inventory and workflow management practices and the monitoring tools and audit trails in place to provide for the timely, accurate adjudication of claims.

### *Manual and Automated Claims Processing Functions*

**Electronic Claims Acquisition (Electronic Data Interface)**

To assist us in processing and paying claims efficiently, accurately and timely; and to best leverage QNXT™'s automated claims processing capabilities, Aetna Better Health encourages network providers to submit claims electronically. To facilitate electronic claims submission, we have developed business relationships with ten major clearinghouses, including Gateway EDI, Emdeon and SSI, among others. We receive EDI claims directly from these clearinghouses, process them through pre-import edits to see to the validity of the data, HIPAA compliance and member enrollment and then upload them into QNXT™ each business day. Within 24 hours of file receipt, we provide production reports and control totals to all trading partners to validate successful transactions and identify errors for correction and resubmission. Our Arizona affiliate, Mercy Care Plan (MCP) has received (from February 2010 and February 2011) 70.4 percent of total claims submissions via EDI. At the same time MCP's EFT transactions rose to over 65 percent and that exceeded the minimum standard for Medicaid health plans in the state.

**Manual Claims Acquisition (Paper)**

Network providers unable to submit claims via EDI can submit paper claims to Aetna Better Health's designated post office box. Each business day, our imaging contractor, FutureVision, retrieves, opens and sorts the mail using our pre-defined criteria for either imaging and scanning or distribution directly to Aetna Better Health. FutureVision assigns each claim a unique reference number based on the date received and use it to track the claim throughout the entire adjudication process. FutureVision then converts the imaged data into an EDI ready format within 24 to 48 hours of receipt and forwards it to Aetna Better Health. Each business day, Aetna Better Health's claims processing personnel upload that data into QNXT™ via EDI processing, where it is accessible to users with approved, secure access to claims information.

Importantly, FutureVision is unable to scan certain documents, including non-claim submissions (e.g., returned member/network provider mail, explanations of benefits, checks, medical records documentation) and certain paper claims (e.g., illegible claims or poor quality printed claims). FutureVision forwards these documents to Aetna Better Health's Claims Administration Department, where they are sorted and distributed to the appropriate department(s). When claims-related, each document is immediately assigned a unique reference number, scanned, indexed for ready retrieval and keyed into QNXT™. Upon successful validation within both Aetna Better Health's imaging system and QNXT™, the hard copy is shredded and disposed of in accordance with policy.

### *Claims Adjudication Processes*

**Auto Adjudication**

Aetna Better Health's IT Department runs batch processes on a daily basis against a comprehensive set of edits that we individually configure based on contractual and regulatory requirements. In 2010, our Arizona affiliate, Mercy Care Plan, auto adjudicated over 75 percent of claims without manual intervention. This rules-based system [QNXT™] allows for setting multiple edits to test claim validity and to determine if claims are paid or denied appropriately. These edits include, but are not limited to:

- Member eligibility
- Covered/non-covered services

- Required documentation
- Services within the scope of the network provider's practice
- Duplication of services
- Prior authorization
- Invalid procedure codes
- Services in excess of benefit limitations
- Services in excess of lifetime benefits

Based on these and other system edits, claims are systematically processed to either a pay, deny or pend status. Those marked "pay" or "deny" are processed in the course of Aetna Better Health's weekly financial cycle, wherein we generate, print and mail payments and corresponding remittance advices to the submitting provider(s), including the minimum required data elements and HIPAA compliant remit comments. Remittance data is also available via AboveHealth®, Aetna Better Health's secure provider Web portal and, by request, in HIPAA 835 format. In some instances, we also provide electronic remittance advices to providers that include all fields required for compliance with the HIPAA 835 format.

Ideally, all claims are "clean claims" and can be processed without the need for additional investigation or information from the service provider or third party. In those instances when a claim cannot be adjudicated as a result of insufficient information, the claim is marked "deny," and returned to the submitting provider with an appropriate remit comment. When the claim is resubmitted with the required information, the original claim is then adjusted for payment per our adjudication rules.

**Manual Adjudication of Pended Claims**

Aetna Better Health assigns a "pend" status to any claim requiring internal attention, such as provider verification, authorization, medical review and/or COB. These pended claims are sent to the appropriate department for research and resolution. For example, should a claim require review for outlier consideration, claims analysts will send the claim to the Medical Management Department, which will then make a determination as to whether the claim will be paid or denied. Once a determination is made, the claim is then sent back to Claims Administration for processing. Should a pended claim assigned to a department other than Claims remain unresolved beyond the required timeframe, the Claims Supervisor will contact the respective department to determine the cause.

In some instances, as in the case of a claim with an Explanation of Benefits attached, pended claims become the responsibility of our own claims analysts, who then manually adjudicate them using a comprehensive set of documented desktop procedures. Regardless of the department assigned, tracking tools and reports provide Claims Supervisors the means to monitor and control the process.

***Claims Inventory and Workflow Management***

Aetna Better Health is committed to achieving the highest level of timeliness in the claims adjudication and payment process. This is accomplished through focused claims inventory and workflow management practices, data monitoring and analysis and management oversight.

As mentioned above, we utilize a suite of tools, scheduled and ad hoc reports to monitor claim receipts, automated claims processing, manual claims adjudication and check and remittance advice production/distribution on a daily, weekly and monthly basis to provide timely claim payment. These tools and reports include, but are not limited to:

- **Pended Claims Tool and Reports** – Claims and other departments use the pended claims tool to track and manage claims that edit out of the auto adjudication process for manual review. Populated hourly, the tool presents claims counts and billed dollars by pend reason and claim age, with drill down capabilities to detailed information on each claim. The tool can sort and filter the data by claim age, claim type, claim form, network provider, and contract. Additionally, daily reports of pended claims inventory are generated for managerial or historical review.
- **Unfinished Claims Tool and Reports** – Claims and other departments use the unfinished claims tool to track and manage all claims that are in process, whether a system batch process or pended for manual review and adjudication. Populated hourly, the tool presents claims counts by process status and claim age, with drill down capabilities to detailed information on each claim. Reports can sort and filter by claim age, claim type, claim form, network provider, and contract. Additionally, daily reports of pended claims inventory are generated for managerial or historical review.
- **Claims Payment Processing Reports** – Finance and Information Technology Departments generate and monitor several process control reports to achieve timely and accurate network provider check and remittance advice production and distribution, whether by mail or electronic funds transfer/electronic remittance advice file. The reports reconcile, through each major process step, the claim counts and amounts from claims waiting payment to payment and remittance advice distribution.
- **Claims Awaiting Payment Forecast** – The Claims Department uses the claims awaiting payment forecast report to predict claims payment turnaround times based on current inventory and future check dates, initiating additional actions as necessary to achieve our claim payment timeliness regulatory requirements.

Monitored daily, Aetna Better Health's Claims Management uses these and other tools and reports to proactively manage the claim workflow and our comprehensively trained personnel to achieve our claims timeliness requirements. If our reports reflect a less than favorable trend, such as during a period of unusual high claim receipts, Claims and other departments work aggressively to address our inventories. We immediately develop and implement action plans, which may include one or more of the following: staff overtime, workload balancing with other Aetna Better Health Medicaid managed care plans and Aetna Medicaid operations personnel, temporary personnel, or increase utilization of overflow vendors to assist with the reduction of claim inventories. Additionally, if claim receipt trends and forecasts indicate, Aetna Better Health's Claims Department will hire and train additional claims personnel in anticipation of increased claim receipts.

On a daily, weekly and monthly basis, we utilize a suite of tools, scheduled and ad hoc reports, claims processing and results data and claims payment feedback from network providers to further support timely claim payment. These tools and reports include, but are not limited to:

- Deny Analysis – The Claims Department uses the deny claims analysis tool to evaluate all deny status claims that are currently awaiting payment, identifying and investigating abnormal denial patterns. The tool presents claims counts for all claims in a deny status by network provider and denial reason, with drill down capabilities to detailed information on each claim.
- **Denial Diagnostics** – Claims and other departments use the denied claims analysis tool to evaluate denied claims, trending and evaluating the claims with their corresponding denial reason, investigating abnormal fluctuations or high levels of denied claims. The tool presents denied claims counts and billed amounts with denial reasons by network provider, contract and QNXT™ adjudication edit, with drill down capabilities to detailed information on each claim.
- **Network Provider Inquiry Tracking** – Claims and other departments use the network provider inquiry tracking tool to monitor, manage, and trend network providers claim inquiries, requests and complaints. The tool presents network provider call counts by network provider, reason, and age, with drill down capabilities to detailed information regarding the call and, when provided, the claim number.

Aetna Better Health's Claims Department and other departments use these tools and reports to proactively manage and to improve our claims payments. If our reports indicate a claims payment issue, our Claims Department investigates and corrects the claim payment, either prior to the initial payment or post-payment. If the issue requires a systemic solution beyond the immediate actions of the Claims Department, an interim solution permitting claims payment is implemented whenever possible until the systemic issue is resolved.

***Claims Adjudication Audit and Quality Review:***

Aetna Better Health adheres to the following standards with regard to claims accuracy:

- Procedural: 95 percent accuracy (determined by the number of claims processed correctly divided by the total number of claims)
- Payment: 98 percent accuracy (determined by the total number of claims paid without dollar errors divided by the total number of claims paid)
- Financial: 99 percent accuracy (determined by total claim dollars paid correctly divided by the total paid claim dollars)

To support these high standards, a random two percent of all adjudicated claims are reviewed on a daily basis. The Quality Review (QR) Unit within the Claims Department conducts all claim audits, using desktop procedures (desktop procedures are detailed instructions for the claims analyst) as their guide.

To further minimize the impact of inaccurate data, daily focused audits are conducted on all claims with billed charges equal to or greater than $50,000. Non-finalized claims with errors are pended for correction prior to the finance payment process. Finalized claim with identified errors are adjusted retrospectively.

New claims analysts have an increased amount of claim audits conducted over the course of their first month following training, starting at 100 percent and decreasing to the standard two percent if they meet the claims accuracy standards defined above.

Aetna Better Health performs internal reviews of check payments on a weekly basis. A statistically valid sample of claims are selected and reviewed against the applicable network provider contract. In addition, Aetna Better Health performs a review of all high dollar claims and performs an audit for appropriate billing prior to the payment of the claims.

**Overpayment and Underpayment of Claims**

Overpayment and underpayment of claims is identified through QNXT™ system edits; audit activities; and information received from network providers and members. When an overpaid/underpaid claim is identified, the claim is reversed or, reversed and reprocessed. The reversed or reprocessed claim is listed on the network provider's remittance advice with a remark indicating that the claim (and the check) has been adjusted and the reason for the adjustment. Recouped amounts, if necessary, are credited to the specific claim in the network provider's claim history; underpaid amounts are reimbursed to the network provider either via check or future remittance advice.

**Remediation Process for Manual Adjudication**

Any claims analyst that fails to meet any of the accuracy levels (payment, procedural or financial) for a given month, receives a documented verbal coaching from the Supervisor. The employee is informed that their quality percentage has dropped below the acceptable rate and is given one month to show improvement. At the end of the month following notification, if there is no noticeable improvement, the employee is provided with a written quality improvement plan. This process can involve additional training and increased audit activity to see that the claims analyst is meeting the required accuracy standards. Failure of any claims analyst to improve substandard accuracy results in further disciplinary action, up to termination.

**Remediation Process for Auto Adjudication**

System Issue Identification Forms (IIF) are submitted to the Business Application Management (BAM) Department for investigation of any suspected system issue. This department conducts a root cause analysis by performing the necessary research, validating the contract or source document against the current system configuration. If a setup issue is discovered, corrections are made and any incorrectly processed claims are identified via a query and forwarded back to the Claims Department for adjustment activities. If appropriate, BAM Department leadership will provide staff coaching and additional training, update the BAM training program, improve configuration methodologies and testing procedures and/or submit product enhancement requests to the TriZetto Group, designer of the QNXT™ application platform.

**Management Oversight**

Aetna Better Health senior leadership reviews claim performance, on a regular basis, addressing any outstanding claim issues or trends as needed. This monitoring includes a weekly CFO review of claims awaiting payment and a monthly CEO review of the claims key indicator reports. Additionally, our operations management team meets weekly. This cross functional team includes Representatives from several disciplines, including network provider services, network provider information management, information technology, finance, claims, business application management and medical management. This meeting includes a standing agenda item for the review of claims inventories, claim payment forecasts, and action planning, when necessary, to achieve timely payment of claims. We have reviewed the claims timeliness standards for DHH and anticipate no problem meeting these requirements.

***Claims Performance Measures***

Aetna Better Health does not differentiate between in-network and out-of-network providers with regard to timeliness of claims payment requirements, holding us to the same performance standards for both. In- and out-of-network providers alike, we measure several claim key indicators, reporting our performance to DHH as required. This key indicator, as well as our respective performance with regard to each over the past 12 months has been stellar.

This outstanding performance speaks to the excellent service which DHH and Aetna Better Health members receive from Aetna Better Health and our operations personnel.

***Related Claims Processing and Management Information System Functions***

Aetna Better Health maintains claims processing activities that include the application of comprehensive clinical and data related edits supporting the efficient, effective adjudication of claims. QNXT™, our core claims adjudication application, has data related edits configured within its software and is supplemented by two clinical claims editing solutions. The first of the two clinical claims editing solutions, iHealth Technologies' (iHT) Integrated Claims Management Services (ICM Services), applies select payment policies from one of the industry's most comprehensive correct coding and medical policy content libraries. The second, McKesson's ClaimCheck®, expands upon those capabilities by enabling our claims management team to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power.

The three applications utilize historic and "new day" claims information to detect questionable billing practices, such as new patient billing codes submitted by the same provider for the same member within a six month period. These applications also assist in identifying fraudulent and abusive billing patterns by generating reports that indicate trending and outliers of provider billing behavior. Inbound claims are initially checked for items such as member eligibility, covered services, excessive or unusual services for gender or age (e.g. "medically unlikely"), duplication of services, prior authorization, invalid procedure codes, and duplicate claims. Claims billed in excess of $50,000 are automatically pended for review, as are any requiring additional documentation (e.g. medical records) in order to determine the appropriateness of the service provided. Professional claims that reach an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), medical policy requirements [e.g., American Medical Association (AMA)], and maximum unit requirements supplied by DHH, with recommendations applied during an automatic re-adjudication process. Other methodologies utilized throughout the auto-adjudication process include, but are not limited to, Multiple Surgical Reductions and Global Day E & M Bundling.

## QNXT™ Data Edits

QNXT™ has over 400 business rules that Aetna Better Health configures to support enforcement of our claims Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promote the accuracy of claim processing against DHH standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service of the provider of record does not match the procedure code billed the claim will pend for manual review to validate accuracy of provider set-up.

Examples of data edits specific to QNXT™ include the following:

***Benefits Package Variations***

QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.

***Data Accuracy***

QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.

***Adherence to Prior Authorization Requirements***

QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized.

***Provider Qualifications***

QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to "Pay" for billing appropriateness by specialty. QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.

***Member Eligibility and Enrollment***

QNXT™ validates the date of service against the member's enrollment segment to determine if the member was eligible on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.

***Duplicate Billing Logic***

QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to "Pay" are subjected to iHealth's duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group

***ClaimCheck® Edits***

ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy

and consistency with Aetna Better Health's P&Ps. ClaimCheck® clinical editing software identifies coding errors in the following categories:

- Procedure unbundling
- Mutually exclusive procedures
- Incidental procedures
- Medical visits, same date of service
- Bilateral and duplicate procedures
- Pre and Post-operative care
- Assistant Surgeon
- Modifier Auditing
- Medically Unlikely

Aetna Better Health offers network providers access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300 provider groups registered to use this web-based tool that providers can use to understand Aetna Better Health's clinical editing logic. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through Aetna Better Health's web portal via secure login. Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.

## iHealth Edits

iHealth clinically edits claims to assist Aetna Better Health to promote the proper and fair payment of professional DME and outpatient claims.

### *Coding Accuracy*

If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).

### *Duplicate Billing Logic*

In addition, claim lines set to "Pay" are subjected to iHealth's duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group

### *Durable Medical Equipment (DME) Editing*

iHealth Technologies' (*i*HT) performs edits related to select DME payment policies that align with ALTCS covered service policies. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.

***Procedure Code Guidelines - iHealth***

Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. *i*HT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, Aetna Better Health would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

***Procedure Code Definition Policies - iHealth***

*i*HT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.

***Fraud & Abuse***

Aetna Better Health's Fraud and Abuse Department, under the direction of the VP of Health Plan Operations, utilizes claims payment tracking and trending reports, claims edits, audits and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting additional analysis and investigation. Aetna Better Health fraud and abuse personnel work in conjunction with Aetna Better Health's Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach. If Aetna Better Health becomes aware that an incident of potential/suspected fraud and abuse has occurred, internal P&Ps mandate that we report the incident to DHH within 10 business days of discovery by completing and submitting the confidential DHH Referral for Preliminary Investigation form.

***Claims Education***

Aetna Better Health's Provider Claims Educator works to educate contracted and non-contracted providers on appropriate claims submission requirements, coding updates and available resources, such as provider manuals, websites, fee schedules, etc. In addition, the Provider Claims Educator will participate in any DHH workgroup tasked with developing uniform guidelines for standardizing hospital outpatient and outpatient provider claim requirements, sharing information with providers accordingly.

***Claims Editing Results***

In calendar year 2010, due to our robust and comprehensive claims editing programs, Aetna Better Health cost avoided/recovered in excess of seventeen million dollars related to the ALTCS program.

***Use of iHealth Technologies to Detect Questionable Billing Practices***

QNXT™ is supplemented by an Integrated Claims Management Services (ICM Services) powered by *i*Health Technologies (*i*HT). This software is seamless to the network provider and allows consistent and accurate administration of claims adjudication policies. Professional claims that reach an adjudicated status of "pay" are automatically reviewed against nationally

recognized standards such as the Correct Coding Initiative (CCI) and recommendations applied during an automatic re-adjudication process.

The QNXT™ and Integrated Claims Management applications utilize historical claims information to detect and correct questionable billing practices and assist in identifying fraudulent and abusive patterns. Professional claims that reach an adjudicated status of "pay" receive a Correct Coding Initiative (CCI) control edit. These edits include, but are not limited to:

**Member Eligibility**
The QNXT™ adjudication system validates the date of service against the member's enrollment segment to determine if the member was eligible on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.

**Covered/Non-Covered Services**
The QNXT™ system automatically determines if specific services using the CPT, REV or HCPC codes are covered under the contract or benefit rules of the DHH plan. If services are not covered, the system will automatically deny that claim line. If the services are up-coded, or unbundled, *i*Health will send a recommendation back to deny the claim line along with the specific reason why. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.

**Required Documentation**
The QNXT™ system is configured, for certain services, to require additional documentation before the claim can be adjudicated. For example, a signed consent form is required documentation for sterilization procedures.

**Services within the Scope of the Network Provider's Practice**
The QNXT™ system is configured by specialty to allow certain procedures to only be performed by selected network provider types. For example, the system does not permit a claim for heart surgery performed in-office by a podiatrist to be processed. In addition to the QNXT™ system, *i*Health also reviews claim lines which are set to pay for network provider billing appropriateness by specialty.

**Duplication of Services**
The QNXT™ system has a very robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service or any combination of these criteria. In addition, claim lines set to pay will go through the *i*Health duplicate logic which will review services rendered by any other physician within the group affiliation for duplicate billings.

**Prior Authorization**
The QNXT™ system has a separate configuration for prior authorization (PA) templates and associated service groups for PA. This allows for flexibility when creating authorizations, which can be accomplished at the code level if needed. The system is organized to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered and units authorized.

**Invalid Procedure Codes**

QNXT™ reference files are configured by year and procedure code. As new codes are added, terminated or changed, we update the codes in the system so that the system is always in compliance with HIPAA standards. If a network provider bills a code that has terminated, the system will deny the claim line and advise the network provider the code is invalid.

***Liability Management Practices***

Aetna Better Health utilizes generally accepted actuarial practices to estimate its unpaid claim liability. Each month, a query is run to extract paid claims by month of service, month of payment, and category of expense. The paid claims extract is reconciled against the check register and is compared to the previous month's extract to validate the data. Then, for each category a completion factor is calculated for each month of service and is applied to the claims paid to date to develop the estimate of ultimate incurred claims for that month. Results are then aggregated across all months of service and all categories of expense. Adjustments for any known liabilities are added as appropriate (for example, a long hospital stay that is known but for which a bill has not yet been received). A margin is added, and the final result is the estimate of Incurred But Not Paid Claims.

Estimated liabilities for Received But Unadjudicated Claims are determined by applying historical factors to the billed charges for these claims. If the estimated liability is high enough to warrant an adjustment to the unpaid claim liability, such an adjustment is made. Incurred But Not Reported Claims are simply the difference between Incurred But Not Paid Claims and Received But Unadjudicated Claims.

Aetna Better Health's corporate valuation actuary makes an independent estimate of Incurred But Not Paid Claims each month. This estimate is compared to Aetna Better Health's estimate, and consensus is reached on the appropriate value to use.

## Retrieval and Integration of Enrollment/Eligibility Data:

Aetna Better Health has over 10 years' experience successfully managing plan membership, as well as a comprehensive system in place that enables us to efficiently resolve discrepancies in membership data. The purpose of reconciling the member file is to maintain correct member eligibility information at all times and pay only for services provided to eligible members. With the eligibility file kept current, capitated network providers are neither overpaid nor underpaid and the eligibility information transferred to subcontractors is correct. Maintaining accurate membership files allows Aetna Better Health to easily reconcile monthly premium payments from the State to the information in QNXT™. It is important that all eligibility segments be recorded in QNXT™ correctly so that medical services are paid only when appropriate.

QNXT™, Aetna Better Health's client/server-based managed care information system, serves as the backbone of our ECM functionality. QNXT™ is used to synthesize the online, phone-based, EFT and ACH capabilities that provide our network providers a comprehensive, cohesive and automated means of claims submission, monitoring and payment. We focus here on those services made available to our network providers by our Claims Inquiry Claims Research (CICR) Line and AboveHealth®, Aetna Better Health's HIPAA-compliant secure Web portal for providers.

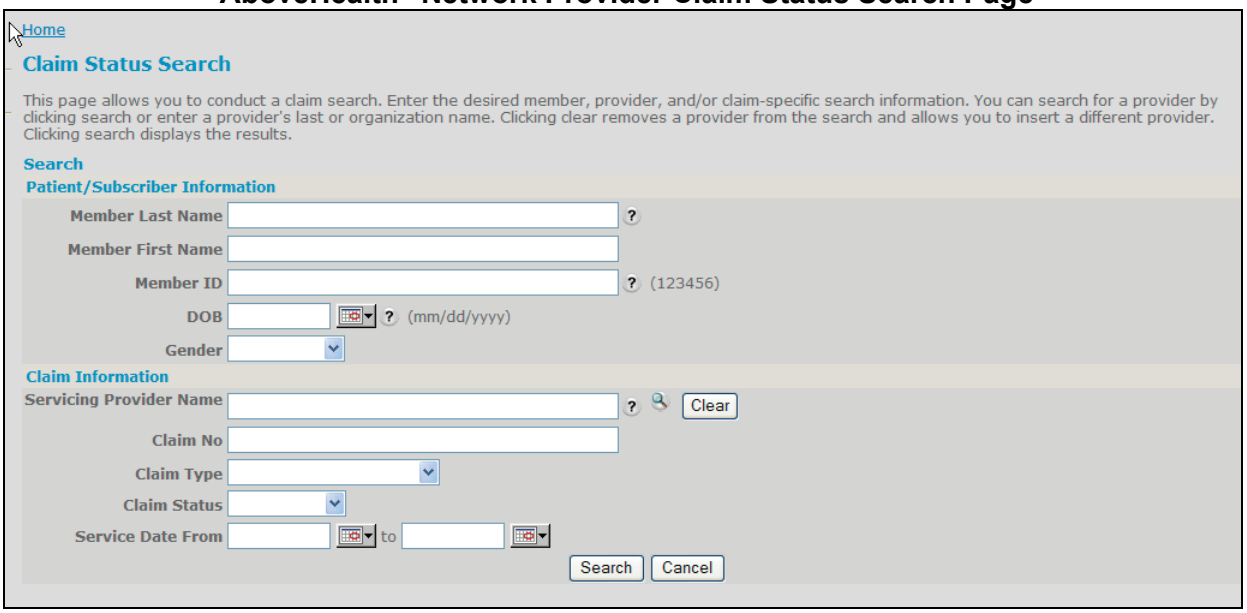
Aetna Better Health's Claims Department maintains a Claims Inquiry Claims Research (CICR) Line, a toll-free number that network providers are free to call between the hours of 6:00 a.m. and 5:00 p.m. to speak with claims research line personnel.

CICR Representatives are specifically designated to answer provider phone inquiries regarding claims status, track those inquiries within QNXT™'s Call Tracking functionality and provide status and/or process adjustments to previously processed claims accordingly. If a single inquiry results in more than three adjustments, the issue is call tracked, by way of QNXT™, to a research and adjustment analyst for processing so that CICR Representatives can remain available to answer provider calls. For every non-status call (requires further action/research) received, a call tracking issue must be opened.

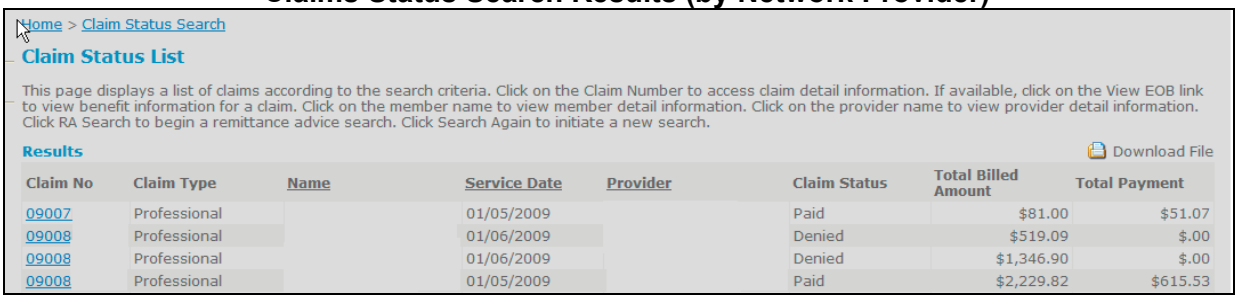
Whenever possible, CICR Representatives resolve provider inquiries in the course of a call. However, in those rare instances when this is not possible, the issue is resolved within seven calendar days. CICR Representatives and Supervisors monitor Call Tracking reports daily to maintain resolution time standards.

With regard to online claims status capabilities, AboveHealth® supports communication between Aetna Better Health and our network providers in a multitude of ways, among them extensive online support of the claim status function. As the screenshots that follow demonstrate, network providers can, at any time, login to AboveHealth®, navigate to the Claim Status Search page, search on multiple criteria, then view and print their search results.

**AboveHealth® Network Provider Claim Status Search Page**



## Claims Status Search Results (by Network Provider)



Home > Claim Status Search

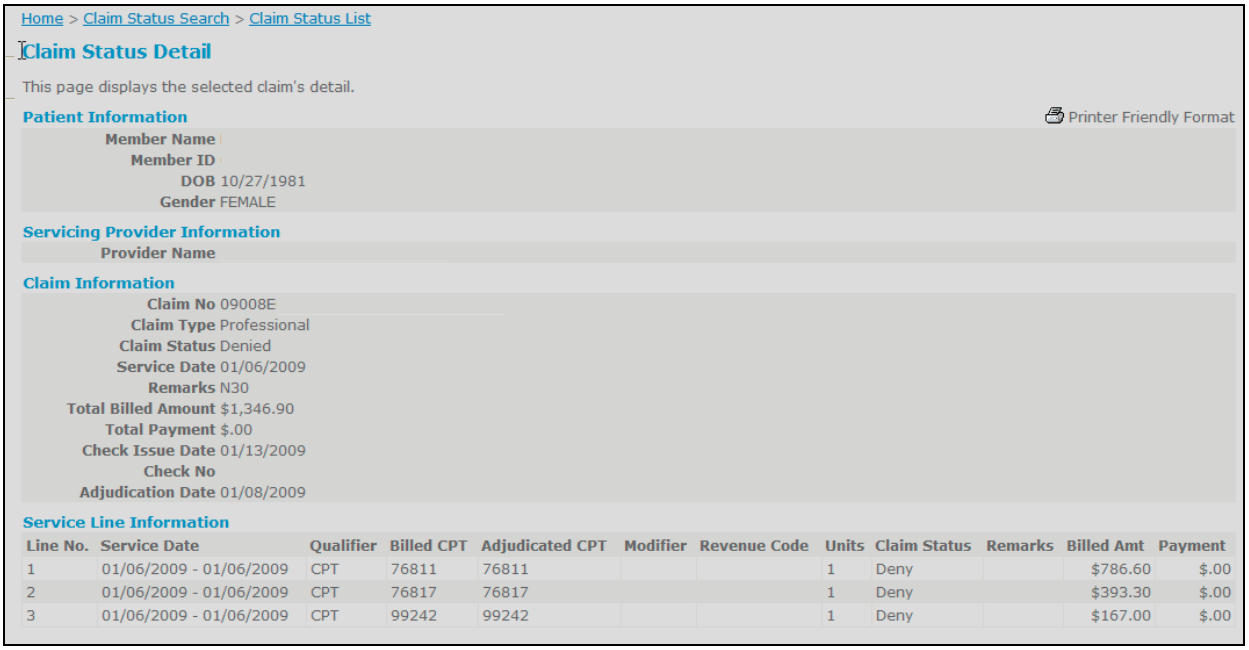
**Claim Status List**

This page displays a list of claims according to the search criteria. Click on the Claim Number to access claim detail information. If available, click on the View EOB link to view benefit information for a claim. Click on the member name to view member detail information. Click on the provider name to view provider detail information. Click RA Search to begin a remittance advice search. Click Search Again to initiate a new search.

**Results** Download File

| Claim No | Claim Type | Name | Service Date | Provider | Claim Status | Total Billed Amount | Total Payment |
|---|---|---|---|---|---|---|---|
| 09007 | Professional | | 01/05/2009 | | Paid | $81.00 | $51.07 |
| 09008 | Professional | | 01/06/2009 | | Denied | $519.09 | $.00 |
| 09008 | Professional | | 01/06/2009 | | Denied | $1,346.90 | $.00 |
| 09008 | Professional | | 01/05/2009 | | Paid | $2,229.82 | $615.53 |

## Claims Detail



Home > Claim Status Search > Claim Status List

**Claim Status Detail**

This page displays the selected claim's detail.

**Patient Information** Printer Friendly Format

Member Name
Member ID
DOB 10/27/1981
Gender FEMALE

**Servicing Provider Information**

Provider Name

**Claim Information**

Claim No 09008E
Claim Type Professional
Claim Status Denied
Service Date 01/06/2009
Remarks N30
Total Billed Amount $1,346.90
Total Payment $.00
Check Issue Date 01/13/2009
Check No
Adjudication Date 01/08/2009

**Service Line Information**

| Line No. | Service Date | Qualifier | Billed CPT | Adjudicated CPT | Modifier | Revenue Code | Units | Claim Status | Remarks | Billed Amt | Payment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 01/06/2009 - 01/06/2009 | CPT | 76811 | 76811 | | | 1 | Deny | | $786.60 | $.00 |
| 2 | 01/06/2009 - 01/06/2009 | CPT | 76817 | 76817 | | | 1 | Deny | | $393.30 | $.00 |
| 3 | 01/06/2009 - 01/06/2009 | CPT | 99242 | 99242 | | | 1 | Deny | | $167.00 | $.00 |

**Claims Status Detail Report (Printable)**

## Claim Status Detail

### Patient Information

| | |
|---|---|
| Member Name | |
| Member ID | |
| DOB | 10/27/1981 |
| Gender | FEMALE |

### Servicing Provider Information

| | |
|---|---|
| Provider Name | |

### Claim Information

| | |
|---|---|
| Claim No | 09008E |
| Claim Type | Professional |
| Claim Status | Denied |
| Service Date | 01/06/2009 |
| Remarks | N30 |
| Total Billed Amount | $1,346.90 |
| Total Payment | $.00 |
| Check Issue Date | 01/13/2009 |
| Check No | |
| Adjudication Date | 01/08/2009 |

### Service Line Information

| Line No. | Service Date | Qualifier | Billed CPT | Adjudicated CPT | Modifier | Revenue Code | Units | Claim Status | Remarks | Billed Amt | Payment |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 01/06/2009 - 01/06/2009 | CPT | 76811 | 76811 | | | 1 | Deny | | $786.60 | $.00 |
| 2 | 01/06/2009 - 01/06/2009 | CPT | 76817 | 76817 | | | 1 | Deny | | $393.30 | $.00 |
| 3 | 01/06/2009 - 01/06/2009 | CPT | 99242 | 99242 | | | 1 | Deny | | $167.00 | $.00 |

**Service ID Qualifier**

| Code | Description |
|---|---|
| CPT | CPT |

**Procedure Code**

| Code | Description |
|---|---|
| 76811 | US PG UTER F&MAT DETAILED FTL XM 1ST GESTATION |
| 76817 | US PG UTER R-T IMG TRVG |
| 99242 | OFFICE CONSLTJ 30 MIN |

**Claim Status Category Code**

| Code | Description |
|---|---|
| Deny | Finalized |

***Provider Training and Education***

For those network providers wishing to take advantage of AboveHealth®'s online claims status inquiry capabilities, Aetna Better Health offers a variety of training opportunities, including, but not limited to the following:

- Orientation sessions
- Distribution of written materials through mailings and on our Website
- Training during scheduled site visits
- Regularly scheduled provider training forums and meetings
- In-person training sessions at provider offices.

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| **17 Claims Management** | | | | |
| **17.1 Electronic Claims Mgmt Functionality** | | | | |
| 17.1.1 The Coordinated Care Network (CCN) shall annually comply with DHH's Electronic Claims Data Interchange policies for certification of electronically submitted claims. | Meets | Meets | Meets | Two applications provide for Aetna Better Health's continued compliance with contracting states' Electronic Claims Data Interchange policies for certification of electronically submitted claims: 1) Microsoft BizTalk with HIPAA Accelerator™ is a data transformation application that translates data to and from the full spectrum of HIPAA transactions sets in a highly customizable, flexible, and robust server-based environment. 2) Washington Publishing Company (WPC) Implementation Guide schemas for each HIPAA ANSI X12 transaction are embedded directly within the application engine, including a facility to update these schemas automatically as the transaction sets are updated over time.<br><br>Additionally, Foresight's HIPAA Validator™, InStream™, is a fully functional HIPAA editing and validation application. It validates HIPAA transactions through all seven levels of edits as defined by the Workgroup for Electronic Data Interchange and Strategic National Implementation Process (WEDI/SNIP), has all standard HIPAA code sets embedded, and supports custom, trading-partner-specific companion guides and validation requirements.<br><br>Aetna Better Health follows the Strategic National Implementation Project (SNIP) recommendations for testing created by the Workgroup for Electronic Data Interchange (WEDI), further promoting system compliance with federal IT mandates. |
| 17.1.2 To the extent that the CCN compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of | Meets | Meets | Meets | QNXT™ , Aetna Better Health's core transaction processing system, comprises 28 integrated modules that maintain the |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| payment, the CCN shall process the provider's claims for covered services provided to members, consistent with applicable CCN policies and procedures and the terms of the Contract and the Systems Guide, including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations. | | | | following:<br>• Claims data, including associated adjudication, COB and TPL processes<br>• Demographic, eligibility and enrollment data, including prior coverage<br>• Provider contract configuration, including network and services<br>• EDI processes<br>• QM/UM including, but not limited to Prior Authorizations and concurrent reviews<br>Under the direction of the Director of Business Application Management (BAM), Aetna Better Health's BAM Department is responsible for:<br>• Designing and documenting the overall configuration and rules needed for the QNXT™ build.<br>• Loading the rules and requirements of any new health plan, product or business function into QNXT™, including eligibility file layout, provider contracts, fee schedules and member benefits and prior authorization requirements. This will allow for the capture, processing and storage of all data elements required by DHH for encounter data submission as stipulated in this Section of the RFP and the Systems Guide.<br>• Validating the overall quality, timeliness and accuracy of the QNXT™ build.<br>• Participating in the claims processing system unit testing with our Operations Process and Knowledge Management |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| | | | | (OPKM) Department and working to resolve any issues.<br>• Participating in end to end testing with end users; resolving any issues during implementations and major system upgrades.<br>QNXT™, in conjunction with the document scanning and OCR functionality afforded by FutureVision, our document management solution vendor, provides for the submission and processing of non-electronic and electronic claims by contracted providers.<br>QNXT's™ interfaces with AboveHeatlh, our secure web portal, in addition to our Avaya phone system, permit providers on-line and phone-based access to claim processing status information. |
| 17.1.3 The CCN shall maintain an electronic claims management system that will: | Meets | Meets | Meets | See below: |
| 17.1.3.1 Uniquely identify the attending and billing provider of each service; | Meets | Meets | Meets | QNXT™, Aetna Better Health's claims processing system, utilizes provider selection logic providing for the unique identification of the attending and billing provider for each service. |
| 17.1.3.2 Identify the date of receipt of the claim (the date the CCN receives the claim and encounter information); | Exceeds | Exceeds | Exceeds | QNXT's™ core functionality records the date any claim or encounter information is received. |
| 17.1.3.3 Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, suspended, appealed, etc., and follow up information on appeals; | Exceeds | Exceeds | Exceeds | Data history is not purged in support of retrieval/review of accurate and comprehensive claim history profiles, e.g. historical data of paid, denied, and suspended claims. (Note that appealed claim data is not stored in the claim's system and instead is stored in the appeals database). The general and administrative database tracks claim history and related adjudication results, thus providing an added mechanism for claims history review. If claim is adjusted as the result of an appeal, the adjustment is |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| | | | | documented in the Claims processing system, and that history is maintained and retrievable. |
| 17.1.3.4 Identify the date of payment, the date & number of the check or other form of payment such as electronic funds transfer (EFT); | Exceeds | Exceeds | Exceeds | The claims system is capable of tracking and maintaining each of these elements, and includes the ability for personnel to query the database for these specific elements. |
| 17.1.3.5 Identify all data elements as required by DHH for encounter data submission as stipulated in this Section of the RFP and the Systems Guide; and | Meets | Meets | Meets | Our proprietary Encounter Management System (EMS) provides for the accurate, timely and complete submission of encounter data –including all billed, paid and denied units and charges, as well as the National Provider Identifier (NPI) – to DHH in HIPAA compliant 837(I/P) format. Developed with the functionality to manage encounter data across the encounter submission continuum – including preparation, review, verification, certification, submission, and reporting – the system consolidates required claims data from multiple sources (e.g. QNXT™ and our delegated vision services provider) for all services (including those in the prior period) for which Aetna Better Health incurred a financial liability, as well as claims for services eligible for processing where no financial liability was incurred. Comprehensive, coordinated edits and workflow management tools identify and address potential data issues at the earliest opportunity. EMS is configured to extract the claim values necessary to populate a valid and accurate encounter. This process will be developed using DHH's specific coding instructions and tested for accuracy and completeness. Our encounter system is custom built for the requirements of each state. We consistently collaborate with the Medicaid agencies that contract with us to provide managed care services. As an example, this collaboration, our affiliate in Arizona, Mercy Care Plan, working with the State's Medicaid agency's encounter |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| | | | | processing unit, contributed to the successful acceptance of over 99 percent of all submitted encounters in calendar year 2010. |
| 17.1.3.6 Allow submission of non-electronic and electronic claims by contracted providers. | Exceeds | Exceeds | Exceeds | Aetna Better Health's claims management system, QNXT™, provides for the submission and processing of electronic claims by contracted providers via multiple clearinghouses. Providers may also submit paper claims to plan-specific post office boxes adjacent to FutureVision, Aetna Better Health's document imaging vendor, providing for their prompt conversion to electronic format and upload to QNXT™, should any supporting documentation be attached (e.g. EOB), their secure delivery to the appropriate Aetna Better Health department. |
| 17.1.4 The CCN shall see that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is in place. | Meets | Meets | Meets | |
| 17.1.5 The CCN shall see that the ECM system functions in accordance with information exchange and data management requirements as specified in this Section of the RFP and the Systems Guide. | Meets | Meets | Meets | Aetna Better Health is able to comply with the information exchange and data management requirements specified in this RFP and the Systems Guide. |
| 17.1.6 The CCN shall see that, as part of the ECM function, it can provide on-line and phone-based capabilities to obtain processing status information. | Meets | Meets | Meets | Online capabilities will be provided via AboveHealth®. AboveHealth® is a secure HIPAA-compliant web portal for Aetna Better Health's members and providers. Designed to foster open communication and facilitate access to a variety of data in a multitude of ways, this secure, ASP-based application synchronizes data on a daily basis with QNXT™ through data extract and load processes, allowing providers to check eligibility status, review benefits, encounters and prior authorization status, and send secure emails to Aetna Better Health.. Phone-based capabilities for claim status and other processing information will be available via our CICR. CICR personnel will be available from 7 am to 7 pm, Central Time, Monday through Friday for provider inquiries. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.1.7 The CCN shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments. | Meets | Meets | Meets | Aetna Better Health affords providers the opportunity to receive payment via direct deposit, or electronic fund transfer (EFT). The process is as follows:<br>1) Providers complete an EFT enrollment form (available online), providing their bank routing and account numbers. The completed from is faxed to our EDI Department.<br>2) Aetna Better Health personnel enter each provider's routing and account information into QNXT™ and designate them as an EFT provider.<br>3) A test document called a "pre-note" is sent to the provider's bank to see that the routing number and account number are accurate and function properly.<br>4) Upon approval of the "pre-note" by the provider's bank, EFT capabilities are enabled within the respective Aetna Better Health accounts.<br>5) As provider payments are generated during the check run process, payment information is compiled within a file and queued for scheduled distribution to the associated banks and Automated Clearing Houses (ACHs) for processing. Upon approval of the check run by the health plan, checks are released for printing and mailing and the EFT file is released to the respective financial institutions.<br>6) Providers receive a hard copy remittance in the mail detailing the claims processed in a particular payment cycle and a paper copy of what would have been a check indicating the EFT check number and total dollars, thereby allowing them to post payments appropriately. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| | | | | Any provider can choose to stop EFT payments at any time and return to payment by physical check by contacting the health plan in writing. |
| 17.1.8 The CCN shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CCN or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges. | Meets | Meets | Meets | Aetna Better Health acknowledges and will comply. It has never been Aetna Better Health's business practice to assess a fee for such services and we are confident that future business practices will continue to support our providers in their adoption of EDI capabilities. |
| 17.1.9 The CCN shall require that their providers comply at all times with standardized billing forms and formats, and all future updates for Professional claims (CMS 1500) and Institutional claims (UB 04). | Meets | Meets | Meets | Aetna Better Health's Claims Educator provides in-network and out-of-network providers (i.e., professional and institutional) in-depth education regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available health plan resources such as provider manuals, websites, fee schedules, and so forth.<br><br>Provider contracts, in conjunction with initial and ongoing provider education and training related to claims requirements, support providers' compliance with regard to claims submission requirements. Preprocessing edits enforce this requirement and deny any claim submitted in a nonstandard format. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.1.10 The CCN must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative. | Meets | Meets | Meets | QNXT's™ data related edits are supplemented by two clinical claims editing solutions. The first, iHealth, applies select payment policies from one of the industry's most comprehensive correct coding and Medical Policy content libraries. The second, McKesson's ClaimCheck®, expands upon those capabilities by enabling our claims management team to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power. Professional claims (CMS 1500s) that reach an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards such National Correct Coding Initiative (NCCI), medical policy requirements [e.g., American Medical Association (AMA)], and can meet maximum unit requirements supplied by DHH, with recommendations applied during an automatic re-adjudication process.<br><br>The use of these two systems combined, along with supportive modules and stated resources, provide for compliance with CCI rules, regulations and related methodologies. |
| 17.1.11 The CCN agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the CCN shall comply with said recommendations within ninety (90) calendar days from notice by DHH. | Meets | Meets | Meets | Aetna Better Health acknowledges and will comply. |
| 17.1.12 The CCN shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include: | Meets | Meets | Meets | The clean date (actual receipt date) of non-electronic claims (paper) is derived from FutureVision, Aetna Better Health's document imaging vendor. This date is a true representation of when the claims were actually received and processed by the image vendor and is embedded within the data file of the claims |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.1.12.1 The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims; | Meets | Meets | Meets | transmitted to us by our image vender. This date will also matches Alchemy (our claim image retrieval application) claim number (Julian date) that is stamped on the images of the each claim.<br><br>The image vendor scans (via OCR technology) the claim and assigns a Document Control Number (DCN) to each claim for tracking and reconciliation purposes. These image files are forwarded to our IT Operations Department, uploaded to Alchemy and linked to the associated electronic claim via DCN.<br><br>FVTech picks up claims from the designated PO Box in the morning, scans and uploads the images, and within 24 to 26 hours of their pick up time at the United States Postal Service, the images are sent to Aetna Better Health, with an image file simultaneously loaded into Alchemy.<br><br>EDI claims are typically received from multiple Clearinghouses, with each Clearinghouse bound by their specific contractual agreement with a Provider. Once EDI claims are received, they are processed via Instream and Level 1 & 2 HIPAA edits are applied. Rejects are then submitted to Aetna EDI Gateway which creates the 277 for the Clearinghouse. It is the Clearinghouse' agreement with the Provider that determines data elements of rejects.<br><br>Claims that are accepted are mass adjudicated and placed in a Pay, Deny or Pend status. Pend & Deny status would indicate an unclean claim. |
| 17.1.12.2 The process for reviewing claims for accuracy and acceptability; | Meets | Meets | Meets | |
| 17.1.12.3 The process for prevention of loss of such claims, and | Meets | Meets | Meets | |
| 17.1.12.4 The process for reviewing claims for determination as to whether claims are accepted as clean claims. | Meets | Meets | Meets | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.1.13 The CCN shall have a procedure approved by DHH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information: | Meets | Meets | Meets | Batch rejections occur at the Clearinghouse and data elements contained in the reports are determined by the Clearinghouses contractual agreement. If a batch is received by Aetna Better Health's Claims Department and rejected here, we submit a report to the Aetna EDI Gateway which in turn creates the 277 for the Clearinghouse. Again, it is the Clearinghouse's agreement with the Provider that determines data elements of rejects. |
| 17.1.13.1 Date batch was received by the CCN; | Meets | Meets | Meets | |
| 17.1.13.2 Date of rejection report; | Meets | Meets | Meets | |
| 17.1.13.3 Name or identification number of CCN issuing batch rejection report; | Meets | Meets | Meets | |
| 17.1.13.4 Batch submitters name or identification number; and | Meets | Meets | Meets | |
| 17.1.13.5 Reason batch is rejected. | Meets | Meets | Meets | |
| 17.1.14 The CCN shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the CCN or to the design of systems within the CCN's span of control. | Meets | Meets | Meets | Aetna Better Health acknowledges and will comply. |
| 17.1.15 The CCN shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH. | Meets | Meets | Meets | Aetna Better Health acknowledges and will comply. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.1.16 For purposes of network management, the CCN shall notify all contracted providers to file claims associated with covered services directly with the CCN, or its contractors, on behalf of Louisiana Medicaid members. | Meets | Meets | Meets | Aetna Better Health's Claims Educator provides in-network and out-of-network providers (i.e., professional and institutional) in-depth education regarding appropriate claims submission requirements. Language within our provider contracts instructs providers to file all claims directly with Aetna Better Health. Claim submission instructions are also included in the Provider Handbook, the provider pages of our website and claims related newsletters and bulletins. The requirement is reiterated during providers' initial orientation and ongoing education by Provider Service Representatives. |
| 17.1.17 At a minimum, the CCN shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CCN and approved by DHH. | Meets | Meets | Meets | Aetna Better Health runs one (1) provider payment cycle per week. |
| **17.2 Claims Processing Methodology Requirements**<br>**The CCN shall perform system edits, including, but not limited to:** | | | | |
| 17.2.1 Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the Enrollment Broker that applies to the period during which the charges were incurred; | Meets | Meets | Meets | Inbound claims are uploaded to QNXT™, our claims processing system, where they are subjected to multiple header and line item edits. Among these are edits that compare service data to eligibility information provided by DHH and the Enrollment Broker in order to confirm members' eligibility during the period to which charges were incurred. |
| 17.2.2 A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following | Meets | Meets | Meets | Level I and II edits occur at the clearinghouse and handled within 5 working days. The clearinghouse bears responsibility for providing exception reports to the providers. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| information: | | | | |
| 17.2.2.1 Member name; | Meets | Meets | Meets | |
| 17.2.2.2 Provider claim number, patient account number, or unique member identification number; | Meets | Meets | Meets | |
| 17.2.2.3 Date of service; | Meets | Meets | Meets | |
| 17.2.2.4 Total billed charges; | Meets | Meets | Meets | |
| 17.2.2.5 CCN's name; and | Meets | Meets | Meets | |
| 17.2.2.6 The date the report was generated. | Meets | Meets | Meets | |
| 17.2.3 Medical necessity; | Meets | Meets | Meets | Clinical edits are capable of verifying when a procedure is for certain gender or an age, e.g., the claim edits will be able to detect if pregnancy-related services are inadvertently being assigned to a male member. Refer to 17.2.4 applies edits accordingly. |
| 17.2.4 Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the CCN granted such approval; | Meets | Meets | Meets | Aetna Better Health's Business Application Management (BAM) Department is responsible for the accurate and efficient configuration of functional business requirements and rules within QNXT™ necessary for administrative services to occur. This includes meeting claims processing standards and auto-adjudication targets. The objectives of the build are to:<br>• Analyze business requirements to design and configure an optimal and efficient system build that will minimize the need for manual processing. |
| 17.2.5 Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed; | Meets | Meets | Meets | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.2.6 Covered Services - See that the system verify that a service is a covered service and is eligible for payment; | Meets | Meets | Meets | • Load the rules and requirements of a new health plan, product or business function in the claims processing system, including eligibility file layout, provider contracts, fee schedules and member benefits and prior authorization requirements.<br>• Complete configuration documentation while entering the build information.<br>• Audit and validate the build based on the rules and requirements stated by the health plan and the implementation team.<br>• Jointly perform unit testing with the Operations Process Knowledge Management (OPKM) Testing team to validate that the system is operational and meets business requirements.<br>• Participate in end-to-end testing with all impacted departments to see that the system is operating as expected. |
| 17.2.7 Provider Validation - See that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted; | Meets | Meets | Meets | |
| 17.2.8 Quantity of Service - See that the system shall evaluate claims for services provided to members to see that any applicable benefit limits are applied; | Meets | Meets | Meets | |
| 17.2.9 Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span; | Meets | Meets | Meets | |
| 17.2.10 Perform post-payment review on a sample of claims to see that services provided were medically necessary; and | Meets | Meets | Meets | Aetna Better Health maintains an independent (i.e. does not report to claims leadership) post-payment Audit Department responsible for drawing stratified random samples and conducting focused audits of paid and denied claims. The purpose of these activities is to audit compliance of claims adjudication with DHH regulatory requirements and provider contracts. Audit findings are shared with Claims management for root cause analysis and corrective action. |
| 17.2.11 Have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity. | Meets | Meets | Meets | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| **17.3 Explanation of Benefits (EOBs)** | | | | |
| 17.3.1 The CCN shall within forty-five (45) days of payment of claims, provide individual notices to a sample group of the members who received services. The required notice must specify: | See explanation | | | Aetna Better Health acknowledges and will comply. All elements required in the Explanation of Benefits will be included in the EOB provided to CCN members. As new EOB requirements and elements are updated, Aetna Better Health will comply and as such, make necessary modifications to existing EOB reported fields as required. |
| 17.3.1.1.1 The service furnished; | | | | |
| 17.3.1.1.2 The name of the provider furnishing the service; | | | | |
| 17.3.1.1.3 The date on which the service was furnished; and | | | | |
| 17.3.1.1.4 The amount of the payment made for the service. | | | | |
| 17.3.2 The CCN shall also: | | | | |
| 17.3.2.1 Include in the sample, claims for services with hard benefit limits, denied claims with member responsibility, and paid claims (excluding ancillary and anesthesia services). | | | | |
| 17.3.2.2 Stratify paid claims sample to see that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CCN considers a particular specialty (or provider) to warrant closer scrutiny, the CCN may over sample the group. The paid claims sample should be a minimum of two hundred (200) to two hundred-fifty (250) claims per year. | | | | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.3.3 The CCN shall track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to DHH. The CCN shall use the feedback received to modify or enhance the EOB sampling methodology. | Meets | Meets | Meets | Aetna Better Health maintains an internal, proprietary application that supports the Grievance and Appeals process by tracking member and provider issues from inception to resolution. This affords us the means to address not only issues affecting individual member and provider satisfaction, but potential trends in the delivery system as a whole, permitting health plan personnel to take prompt, corrective steps to minimizing risks to performance standards. Feedback received during this process or feedback received through other means, will be shared with the appropriate personnel within the Claims unit for future handling and modifications in concert with the IT Department. Aetna Better Health will use the feedback received via the member compliant system to improve our EOB sampling methodology. Results of member feedback will be reviewed by our Service Improvement Committee (SIC) and results forwarded to QM/UM Committee for review and recommendations developed. |
| **17.4 Remittance Advices**<br>**In conjunction with its payment cycles, the CCN shall provide:** | | | | |
| 17.4.1 Each remittance advice generated by the CCN to a provider shall, if known at that time, clearly identify for each claim, the following information: | Meets | Meets | Meets | QNXT™, Aetna Better Health's core transaction processing system, generates paper Remittance Advices (RAs) for our providers. In addition, providers taking advantage of our Electronic Fund Transfer (EFT) capability have the option of receiving Electronic Remittance Advices (ERAs). Business Application Management (BAM) personnel configure QNXT™ to generate RAs formatted such that required data elements are readily identifiable. |
| 17.4.1.1 The name of the member; | Meets | Meets | Meets | |
| 17.4.1.2 Unique member identification number; | Meets | Meets | Meets | |
| 17.4.1.3 Patient claim number or patient account number; | Meets | Meets | Meets | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.4.1.4 Date of service; | Meets | Meets | Meets | |
| 17.4.1.5 Total provider charges; | Meets | Meets | Meets | |
| 17.4.1.6 Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount; | Meets | Meets | Meets | |
| 17.4.1.7 Amount paid by the CCN; | Meets | Meets | Meets | |
| 17.4.1.8 Amount denied and the reason for denial; and | Meets | Meets | Meets | |
| The following statement shall be included on each remittance advice sent to providers: "I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws." | Meets | Meets | Meets | Aetna Better Health's existing remittance advice can be configured to meet this requirement. |
| **17.5 Adherence to Key Claims Management Standards** | | | | |
| **17.5.1 Prompt Payment to Providers** | | | | |
| 17.5.1.1 The CCN shall see that ninety percent (90%) of all clean claims for payment of services delivered to a member are paid by the CCN to the provider within fifteen (15) business days of the receipt of such claims. | See explanation | | | Aetna Better Health presently manages its claims payment process such that State mandated payment timeframes are either met or exceeded by the Claim's Unit. For example, in Florida, Aetna Better Health manages the claim process such that the entire claims process is completed with 12 days on average, with an added 7 days tagged on to the process to account for check issuance purposes, so that the total time to process, on average is 20 business days (the requirement is 20 days), thus the claim payment time exceeds the mandatory timeframe in Florida. Aetna Better Health anticipates also exceeding the expectations |
| 17.5.1.2 The CCN shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a | See explanation | | | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| member. | | | | of the Louisiana Department of Health's which provide for payment of 90% of clean claims within fifteen days and 99% payment within the allotted thirty calendar day timeframe. |
| 17.5.1.3 If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing. | Meets | Meets | Meets | When an otherwise claim denies specifically on the basis of lack of documentation required to process the claim, the remittance advice identifies with specificity the reason for the denial. Providers are instructed to resubmit the claim, along with the required document and to notate that the claim is a resubmission. As such, those claims with the "resubmission" notation receive are adjudicated for timely filing using the original submission date of the claim. |
| 17.5.1.4 To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than:<br>• The time period specified in the provider contract between the provider and the CCN, or if a time period is not specified in the contract:<br>– The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or<br>– If the CCN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH. | Meets | Meets | Meets | Aetna Better Health capitated contracts provide for payment by the 15th calendar day of the month. Network providers indicate their agreement with this timeframe as evidenced by their signing the agreement and the specific provider rate attachment. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.5.1.5 The CCN shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim. | Meets | Meets | Meets | Aetna Better Health acknowledges and will comply. Aetna Better Health acknowledges DHH's timely failing related to subrogated or COB claims and will comply with said requirements. It is Aetna Better Health's standard operating procedure to accept claims that are within the statutorily allotted timely filing limits, and those timeframes and other considerations applicable to subrogated claims or coordination of benefits |
| 17.5.1.6 The CCN shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH. | Meets | Meets | Meets | As part of our credentialing process, Aetna Better Health queries the listing of excluded individuals, pursuant to the requirements of section 1128 or 1156 of the Social Security Act, and sees that those providers treating members covered under the agreement between Aetna Better Health and the DHH, are in good standing with DHH prior to completing the contracting and credentialing process. At recredentialing, the procedures are followed to make certain good standing with DHH and lack of exclusion or restriction for participation in a Medicaid, Medicare or other government healthcare program. Aetna Better Health, through its vendor PDS, also conducts queries of non-network providers, on a periodic and random basis, to supplement its existing query processes related to the contracted network. |
| **17.5.2 Claims Dispute Management** | | | | |
| 17.5.2.1 The CCN shall have an internal claims dispute procedure that shall be submitted to DHH within thirty (30) days of the date the Contract is signed by the CCN, which will be reviewed and approved by DHH. | Meets | Meets | Meets | Aetna Better Health's Claims Administration Department employs full-time claims inquiry and Research Representatives to respond to provider questions, status inquiries and claims payment disputes via the claims inquiry line from 8:00 a.m. to 5:00 p.m., Monday through Friday. An automated telephone system allows callers to speak directly with a Representative or leave a detailed message regarding their inquiry. |
| 17.5.2.2 The CCN shall contract with independent reviewers to review disputed claims. | Meets | Meets | Meets | |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| 17.5.2.3 The CCN shall systematically capture the status and resolution of all claim disputes as well as all associated documentation. | Meets | Meets | Meets | Whenever possible, the provider inquiry will be resolved while the provider is on the phone. If the provider's inquiry cannot be resolved while the provider is on the phone and the provider's inquiry requires additional research to reach resolution, then a call tracking case will be open for the provider's issue. It is the department's goal to research and respond to the provider's issues within five to ten business days. When it is not possible to resolve the issue within this time frame, then the issue will be call tracked to the appropriate department, and thereafter followed by an independent reviewer. Claim disputes may escalate, at the request of the provider, to the Grievance and Appeals process. As such time, established Grievance and Appeals procedures are followed and applied to the provider's claim dispute.<br><br>Aetna Better Health acknowledges and will comply with the requirement to submit its specific claims dispute policies to the DHH within 30 days of contract award.<br><br>Claim dispute data is captured by Aetna Better Health in its systems and further documented through the Grievance and Appeals process, as applicable. |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| **17.5.3 Claims Payment Accuracy Report** | | | | |
| 17.5.3.1 On a monthly basis, the CCN shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the CCN. The audit shall be conducted by an entity or personnel independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission. | Exceeds | Exceeds | Exceeds | Aetna Better Health maintains a Claims Quality Review Team to monitor quality standards for all claims processes. Under the direction of the director of Operations Process and Knowledge Management (OPKM), Quality Review Analysts conduct random and focused reviews of processed claims for payment, financial and procedural accuracy and provider inquiry calls, which focus on both accuracy and customer service skills. Performance is measured against established department guidelines.<br><br>Moreover, the Claims Quality Review Team fully audits the work of all new claims analysts for at least one month subsequent to their orientation and training. The audit starts at 100 percent of their work product and decreases to a standard two percent by the fifth week, provided the new claims analyst continues to meet claims accuracy standards. Finally, we review 16 provider calls per Claims Inquiry Representative per month, assessing the quality of service interaction and accuracy of information provided. Individual quality reports are presented to the Representative and their Supervisor for corrective action (e.g., live call monitoring) if appropriate.<br><br>Quality Review Analysts conduct a series of pre-payment audits including:<br><br>1) A one percent random sample of system-adjudicated claims,<br><br>2) A two percent random sample of all analyst-adjudicated claims,<br><br>3) A daily random sample of billed claims up to $49,999.99, and |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| | | | | 4) 100 percent of all claims with billed charges over $50,000.<br>We will have one full time Auditor assigned and we will pull a total of 4 audits per month; two UB (facility) files and two 1500 (physician) files based on a two week paid date/check cycle. Our sample size is 95/2/2 (95% confidence; the error rate is 2%; with a desired precision of +/- 2%) which is an average of 180+ claims reviewed each week. Each file provides Aetna Better Health with Payment and Financial Accuracy findings for the period audited and each file is distributed for review and response to all applicable departments. |
| 17.5.3.2 The minimum attributes to be tested for each claim selected shall include:<br>• Claim data correctly entered into the claims processing system;<br>• Claim is associated with the correct provider;<br>• Proper authorization was obtained for the service;<br>• Member eligibility at processing date correctly applied;<br>• Allowed payment amount agrees with contracted rate;<br>• Duplicate payment of the same claim has not occurred;<br>• Denial reason applied appropriately;<br>• Co-payment application considered and | Exceeds | Exceeds | Exceeds | Post-payment audits review, at a minimum, include audit for the attributes listed in requirement 17.5.3.2., and also provide for review of:<br>• Valid Coding, e.g. proper use of codes and modifier codes;<br>• Member eligibility;<br>• Data entry into the systems is accurate;<br>• Timely Filing;<br>• Claim is associated with the correct treating provider;<br>• Prior Authorization requirements;<br>• Denial reasons applied correctly;<br>• Benefit application (including limitations and exclusions);<br>• Coordination of Benefits application;<br>• Claims history review for duplicate claim;<br>• Manual Pricing application; |

| Requirement | Delaware | Florida | Maryland | Explanation |
|---|---|---|---|---|
| | Meets or Exceeds Requirement | | | |
| applied, if applicable;<br>• Effect of modifier codes correctly applied; and<br>• Proper coding. | | | | • Contracted Provider and Special Provider agreements, such as one-time case agreements and for both ensuring payment amount agrees with contracted rate;<br>• Modifier Discounts; and<br>• Claims bundling/unbundling. |
| 17.5.3.3 The results of testing at a minimum should be documented to include:<br>• Results for each attribute tested for each claim selected;<br>• Amount of overpayment or underpayment for each claim processed or paid in error;<br>• Explanation of the erroneous processing for each claim processed or paid in error;<br>• Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and<br>• Claims processed or paid in error have been corrected. | Exceeds | Exceeds | Exceeds | Audit documentation comprises, at a minimum, documentation of findings by attribute, the amount of the associated under/overpayment, the root cause and resolution status. Audit files remain 'open' until all identified issues have been resolved and corrections/adjustments implemented accordingly. |
| 17.5.3.4 If the CCN contracted for the provision of any covered services, and the CCN's contractor is responsible for processing claims, then the CCN shall submit a claims payment accuracy percentage report for the claims processed by the contractor. | Exceeds | Exceeds | Exceeds | Delegated vendors are required to match Aetna Better Health's Claims auditing procedures. To monitor compliance with this contractual requirement, Aetna Better Health conducts a semi-annual and annual evaluation of delegated vendor claims auditing processes, and we will include a review of DHH specific audit requirements as part of our delegation oversight process. |

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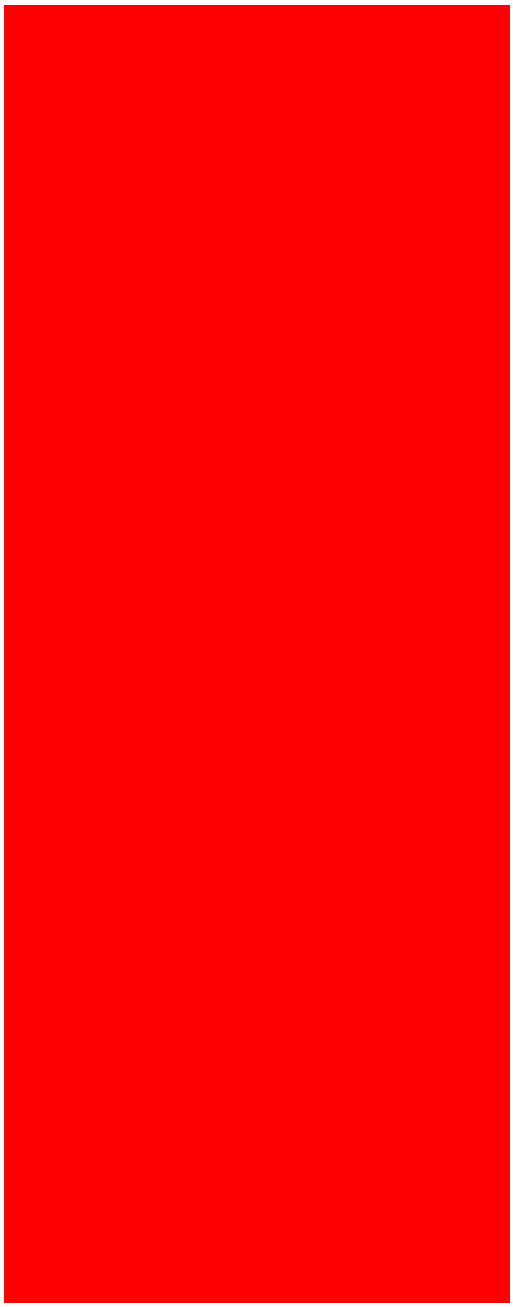


**Q.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:**

- **The process for auditing a sample of claims as described in Key Claims Management Standards Section;**
- **The sampling methodology itself;**
- **Documentation of the results of these audits; and**
- **The processes for implementing any necessary corrective actions resulting from an audit.**

## Methodology for Claims Payment Accuracy Standards

### *Claims Accuracy Standards Introduction*

Aetna Better Health takes pride in our claims performance, nationally – for all Aetna Better Health affiliates, we adjudicate over 80 percent of clean claims within 10 days of receipt and over 95 percent within 30 days of receipt. We also continuously evaluate methods to improve our payment processes and streamline payment. Our processing goal is to adjudicate 90 percent of all Louisiana clean claims within 15 business days of receipt and 99 percent within 30 business days of receipt. When a claim reaches either a pay, deny or reverse status, it is ready for final processing. We process claims in a pay status through weekly finance payment runs.

Our claims processing system determines the timeliness of claims adjudication. We use the claim's receipt/clean date to calculate the submission window. Discounts are calculated at the time of the check run based on the receipt date of the claim. Within 48 hours of receiving a "pay status" claim, Aetna's Automated Business Fulfillment (ABF) generates, prints and mails payments and corresponding remittance advice to providers, including the minimum required information elements as well as HIPAA compliant remit comments. We also provide electronic remittance advices to providers that include all fields required for compliance with the HIPAA 835 format.

For those clean claims which are denied due to lack of required or additional information necessary to review the claim, then the remittance advice will indicate the denial reason, with specificity, so that the provider is able to take the necessary action in support of claim resubmission. Additionally, Aetna Better Health providers are instructed to indicate that a claim is a "resubmission" and as such, allows the provider claim to be adjudicated using the same timely filing date as the original claim.

### *Key Claims Management Standards*

1) **Requirement** - On a monthly basis, the Coordinated Care Network (CCN) shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the CCN. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year,

based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.

**Response:** Aetna Better Health's Claims Audit Department conducts an average of 48 post-payment audits a year; performing approximately two CMS1500 and two UB04 audits each month, thus exceeding the DHH's requirements. Auditors review on average 187 Paid/Denied claims per health plan per week, depending on claim volume. The unit operates independent of our Claims Department and bears responsibility for submission of the monthly Claims Accuracy Percentage Report to DHH.

2) **Requirement** - The CCN shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a member.

**Response:** Aetna Better Health presently manages its claims payment process such that State mandated payment timeframes are either met or exceeded by the Claim's Unit. For example, in Florida, Aetna Better Health manages the claim process such that the entire claims process is completed with 12 days on average, with an added 7 days tagged on to the process to account for check issuance purposes, so that the total time to process, on average is 20 business days (the requirement is 20 days), thus the claim payment time exceeds the mandatory timeframe in Florida. Aetna Better Health anticipates also exceeding the requirements of the Louisiana DHH, which provide for payment of 90% of clean claims within fifteen days and 99% payment within the allotted thirty calendar day timeframe.

3) **Requirement** - If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, and then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing.

**Response:** When an otherwise clean claim denies specifically on the basis of lack of documentation required to process the claim, the remittance advice identifies with specificity the reason for the denial. Providers are instructed to resubmit the claim, along with the required document and to notate that the claim is a resubmission. As such, those claims with the "resubmission" notation receive are adjudicated for timely filing using the original submission date of the claim.

4) **Requirement** - To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than:

The time period specified in the provider contract between the provider and the CCN, or if a time period is not specified in the contract:

- The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or

- If the CCN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH.

**Response:** Aetna Better Health capitated contracts provide for payment by the 15th calendar day of the month. Network providers indicate their agreement with this timeframe as evidenced by their signing the agreement and the specific provider rate attachment.

5) The CCN shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.

**Response:** Aetna Better Health acknowledges DHH's timely failing related to subrogated or COB claims and will comply with said requirements. It is Aetna Better Health's standard operating procedure to accept claims that are within the statutorily allotted timely filing limits, and those timeframes and other considerations applicable to subrogated claims or coordination of benefits.

6) **Requirement** - The CCN shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.

**Response:** As part of our credentialing process, Aetna Better Health queries the listing of excluded individuals, pursuant to the requirements of section 1128 or 1156 of the Social Security Act, and sees that, through the same process, those providers treating members covered under the agreement between Aetna Better Health and the DHH, are in good standing with DHH prior to completing the contracting and credentialing process. At re-credentialing, the procedures are followed to make certain good standing with DHH and lack of exclusion or restriction for participation in a Medicaid, Medicare or other government healthcare program. Aetna Better Health, through its vendor PDS, also conducts queries of non-network providers, on a periodic and random basis, to supplement its existing query processes related to the contracted network.

7) **Requirement -** Post-payment audits review, at a minimum,

- Results for each attribute tested for each claim selected;
- Amount of overpayment or underpayment for each claim processed or paid in error;
- Explanation of the erroneous processing for each claim processed or paid in error;
- Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and
- Claims processed or paid in error have been corrected.

**Response:** Aetna Better Health's auditing processes exceed the DHH's mandated audit elements and also include documentation of findings by attribute, the amount of

the associated under/overpayment, the root cause and resolution status. Audit files remain 'open' until all identified issues have been resolved and corrections/adjustments implemented accordingly.

8) **Requirement:** If the CCN contracted for the provision of any covered services, and the CCN's contractor is responsible for processing claims, then the CCN shall submit a claims payment accuracy percentage report for the claims processed by the contractor.

**Response:** Delegated vendors are required to match Aetna Better Health's Claims auditing procedures. To monitor compliance with this contractual requirement, Aetna Better Health conducts a semi-annual and annual evaluation of delegated vendor claims auditing processes, and we will include a review of DHH specific audit requirements as part of our delegation oversight process.

***Claims Auditing Process***

Aetna Better Health maintains a Claims Quality Review Team to monitor quality standards for all claims processes. Under the direction of the director of Operations Process and Knowledge Management (OPKM), Quality Review Analysts conduct random and focused reviews of processed claims for payment, financial and procedural accuracy and provider inquiry calls, which focus on both accuracy and customer service skills. Performance is measured against established department guidelines.

Moreover, the Claims Quality Review Team fully audits the work of all new claims analysts for at least one month subsequent to their orientation and training. The audit starts at 100 percent of their work product and decreases to a standard two percent by the fifth week, provided the new claims analyst continues to meet claims accuracy standards. Finally, we review 16 provider calls per Claims Inquiry Representative per month, assessing the quality of service interaction and accuracy of information provided. Individual quality reports are presented to the Representative and their Supervisor for corrective action (e.g., live call monitoring) if appropriate.

Quality Review Analysts conduct a series of pre-payment audits including:

1) A one percent random sample of system-adjudicated claims,
2) A two percent random sample of all analyst-adjudicated claims,
3) A daily random sample of billed claims up to $49,999.99, and
4) 100 percent of all claims with billed charges over $50,000.

Aetna Better Health will have one full-time auditor assigned and we will pull a total of four audits per month: two UB (facility) files and two 1500 (physician) files based on a two week paid date/check cycle. Our sample size is 95/2/2 (*95% confidence; the error rate is 2%; with a desired precision of +/- 2%*) which is an average of 180+ claims reviewed each week. Each file provides Aetna Better Health with Payment and Financial Accuracy findings for the period audited and each file is distributed for review and response to all applicable departments. Below is a summary of the claim audit process utilized by an auditor:

**Random Statistically Valid (RSV) process:** Standard audit sample sizes are determined using a statistically valid sample, based on the total population size. The Claims Audit RSV table uses

an algorithm to determine the level of confidence, expected error rate and the desired precision required, as validated by Aetna Better Health and its affiliate Actuarial Department. The RSV size and total population is documented on each audit file. An automated program is utilized to extract the random claims sample with a proportion of paid or denied claims consistent with the total population.

**Payment Accuracy**– Reflects the percent of accurate claims. *Calculation: The total number of audited claims correctly paid, divided by the total number of claims audited.*

**Financial Accuracy** – Reflects the percent of dollars paid appropriately. *Calculation: (Total $ Paid - $ Overpaid) + $ Underpaid = Total Correct Paid then (Total Correct Paid - Total $ Incorrect) / Total Correct Paid.*

**Claim Audit Process:** In this step, contractual appropriateness of the provider attachment to the contract, e.g., fee schedules in accordance to the contract, is validated.

- **Provider Validation:** All contracted providers have a signed contract on file that is accessible for use by the Claims Department and the designated auditor(s). The auditor validates the contractual appropriateness of the provider attachment to the source documentation and reports any discrepancies, and simultaneously notifies the Network Development Department of the discrepancy and track on the audit file.
- **Contract Validation:** All provider network contracts should be accessible for use by the Audit Department. Validate the contract system configuration for appropriateness to the source documentation and report any discrepancies, and notify the Business Applications Management Department and track on the audit file. Each claim line is analyzed for appropriateness of contract term selection during the audit process.
- **Benefit Validation:** Benefits are validated by referring to the listing of Medicaid/DHH covered services, which should be accessible for use by the Audit Department. Validate the benefit system configuration for appropriateness to the source documentation and report any discrepancies, including reporting to the Business Applications Management Department and track on the audit file. Each claim line is analyzed for appropriateness of the benefit term selection during the audit process.
- **Claim Validation:** Data field validation for each claim can be verified either through viewing the paper claim submitted via Alchemy or viewing the EDI data submitted. All claims are subjected to analysis that involves but is not limited to the following:
  - Valid Coding, e.g. proper use of codes and modifier codes;
  - Member eligibility;
  - Data entry into the systems is accurate;
  - Timely Filing;
  - Claim is associated with the correct treating provider;
  - Prior Authorization requirements;
  - Denial reasons applied correctly;
  - Benefit application (including limitations and exclusions);

- Coordination of Benefits application;
- Claims history review for duplicate claims;
- Manual pricing application;
- Contracted Provider and Special Provider agreements, such as one-time case agreements and for both ensuring payment amount agrees with contracted rate;
- Modifier discounts; and
- Claims bundling/unbundling.

***Claims Payment Accuracy Percentage Report and Audit***

On average, Aetna Better Health's Claims Audit Department conducts an average of 48 randomized, post-payment audits a year; performing approximately two CMS1500 and two UB04 each month of both paper and electronically processed or paid claims. Auditors review on average 187 Paid/Denied claims per health plan per week, depending on claim volume, as such; we exceed the DHH's mandate to sample up to 250 claims per year. Additional, the audit unit operates independently of our Claims Department and bears responsibility for submission of the monthly Claims Accuracy Percentage Report to DHH.

***Sampling Frame***

- Random audit of billed claims, up to $49,999.99, on a daily basis
  - Quality standard maintained at 95% for external procedural (98% for Pennsylvania)
  - Quality standard maintained at 98% for payment
  - Quality standard maintained at 99% for financial accuracy
- 16 calls randomly audited for each CICR analyst on a monthly basis
  - Quality standard maintained at 95%
- 100% daily audit of billed claims, $50,000 and greater, on a daily basis
  - Quality standard maintained at 95% for external procedural (98% for Pennsylvania)
  - Quality standard maintained at 98% for payment
  - Quality standard maintained at 99% for financial accuracy
- New employees audited at descending rate starting at 100% post training
  - Quality standard maintained at 95% for external procedural (98% for Pennsylvania)
  - Quality standard maintained at 98% for payment
  - Quality standard maintained at 99% for financial accuracy
- Random audit of 1% of claims that have been systematically adjudicated
  - Quality standard maintained at 95% for external procedural
  - Quality standard maintained at 98% for payment
  - Quality standard maintained at 99% for financial accuracy
- Three closed PCR audited per day, per eligible PDA
  - Quality standard maintained at 98% accuracy

***Edits Utilized in Support of Claim Adjudication and Accuracy Standards***

Aetna Better Health maintains claims processing activities that include the application of comprehensive clinical and data related edits supporting the efficient, accurate, effective adjudication of claims. QNXT™, our core claims adjudication application has data related edits configured within its software and is supplemented by two clinical claims editing solutions. The first of the two clinical claims editing solutions, iHealth Technologies' (iHT) Integrated Claims Management Services (ICM Services), applies select payment policies from one of the industry's most comprehensive correct coding and Medical Policy content libraries. The second, McKesson's ClaimCheck®, expands upon those capabilities by enabling our claims management team to define and combine specific claims data criteria, such as eligibility, provider or diagnosis, duplicate claims and other unique edits we set up to deliver enhanced auditing power.

The three applications utilize historic and "new day" claims information to detect questionable billing practices, such as new patient billing codes submitted by the same provider for the same member within a six month period or other improper or invalid coding schematics. These applications also assist in identifying fraudulent and abusive billing patterns by generating reports that indicate trending and outliers of provider billing behavior. Inbound claims are initially checked for items such as member eligibility, covered services, excessive or unusual services for gender or age (e.g. "medically unlikely"), duplication of services, prior authorization, invalid procedure codes, and duplicate claims. Claims billed in excess of $50,000 are automatically pended for review, as are any requiring additional documentation (e.g. medical records) in order to determine the appropriateness of the service provided. Professional claims that reach an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), medical policy requirements [e.g., American Medical Association (AMA)], and other requirements.

**QNXT™ Data Edits**

QNXT™ has over 400 business rules that MCP configures to support enforcement of our claims Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promote the accuracy of claim processing against AHCCCS standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service of the provider of record does not match the procedure code billed the claim will pend for manual review to validate accuracy of provider set-up.

Examples of data edits specific to QNXT™ include the following:

**Benefits Package Variations**

QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.

**Data Accuracy**

QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider

bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.

**Adherence to Prior Authorization Requirements**

QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized.

**Provider Qualifications**

QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to "Pay" for billing appropriateness by specialty.

QNXT™ checks other provider-specific items as well, verifying, for example, that each provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.

**Duplicate Billing Logic**

QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to "Pay" are subjected to iHealth's duplicate logic. This logic protects against MCP paying for services rendered by the same physician or other physicians within the same provider group

**ClaimCheck® Edits**

ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with Aetna Better Health policies and procedures. ClaimCheck® clinical editing software identifies coding errors in the following categories:

- Procedure unbundling
- Mutually exclusive procedures
- Incidental procedures
- Medical visits, same date of service
- Bilateral and duplicate procedures
- Pre and Post-operative care
- Assistant Surgeon
- Modifier Auditing
- Medically Unlikely

Network providers do received access to Clear Claim Connection®, a provider reference tool that helps providers optimize their claims submission accuracy. Currently there are 2300

provider groups have registered to use this web-based tool that providers can use to understand clinical editing logic utilized by Aetna Better Health. This allows them to better understand the rules and clinical rationale affecting adjudication. Providers access Clear Claim Connection® through Aetna Better Health's internet web portal via secure login.

Various coding combinations can then be entered to determine why, for example, a particular coding combination resulted in a denial. The provider may also review coding combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted.

**iHealth Edits**

iHealth clinically edits claims to assist Aetna Better Health to promote the proper and fair payment of professional DME and outpatient claims.

**Coding Accuracy**

If the services are up-coded, or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).

**Duplicate Billing Logic**

In addition, claim lines set to "Pay" are subjected to iHealth's duplicate logic. This logic protects against Aetna Better Health paying for services rendered by the same physician or other physicians within the same provider group

**Durable Medical Equipment (DME) Editing**

iHealth Technologies' (*i*HT) performs edits related to select DME payment policies that align with Medicaid covered service policies. These DME edits include but are not limited to; DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.

**Procedure Code Guidelines - iHealth**

Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which both provide instructions regarding code usage. *i*HT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, Aetna Better Health would then deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

**Procedure Code Definition Policies - iHealth**

*i*HT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. These editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate evaluation and management or office code.

**Fraud & Abuse**

Aetna Better Health's Fraud and Abuse Department, under the direction of the VP of Health Plan Operations, utilizes claims payment tracking and trending reports, claims edits, audits and provider billing patterns as indicators of potential fraud and abuse. The Fraud and Abuse Department uses this information to detect aberrant provider billing behavior, prompting additional analysis and investigation. Aetna Better Health's fraud and abuse personnel work in conjunction with Aetna Better Health's Provider Services and Compliance Departments to address the questionable behavior(s) through provider education and outreach. If MCP discovers, or becomes aware, that an incident of potential/suspected fraud and abuse has occurred, internal P&Ps mandate that we report the incident to AHCCCS within 10 business days of discovery by completing and submitting the confidential AHCCCS Referral for Preliminary Investigation form.

**Claims Audit and Ongoing Accuracy Monitoring – Supportive Tools**

Aetna Better Health facilitates inter-departmental exchange of information and the external exchange of information between these departments and our providers through reporting and other educational interactions. We then inform providers of, among other things, any issue(s) potentially impacting claim adjudication or any opportunities for provider education. We utilize a suite of tools, including but not limited to, scheduled and ad hoc reports to monitor claim receipts, automated claims processing, manual claims adjudication, and check and remittance advice production/distribution. These tools and reports include, but are not limited to:

Pended Claims and Aging Report – the pended and aging claim reports allow management to effectively intervene when and where necessary to improve accurate and timely adjudication of claims. Populated hourly and reviewed daily, the tool presents claims counts and billed dollars by pend reason and claim age, with drill down capabilities to gather for review detailed claims information.

In-Process Claim Reports – In-process claims report allow management to effectively track and manage all claims in process so that needed interventions may be applied to improve the accuracy and timeliness of claim adjudication.

Claims Payment Processing Reports – This is a set of retrospective claims adjudication reports that are produced and reviewed weekly to provide claims, health plan operations and finance units with data to support reconciliation of claim volume and adjudicated dollars including information to support the reinsurance process.

Monthly Claims Dashboard –This management tool can be used to identify trends related to critical claims metrics. The claims dashboard is reviewed monthly by compliance, encounters, health plan operations, and finance personnel to identify appropriate action plans.

These reports are also utilized to proactively manage claims workflow so that timeliness is addressed before it becomes an issue. For example, based on such analysis, the Claim Department can take proactive action to address any trends that indicate a potential issue such as turnaround times or inventory levels for aging claims. It is our standard operating procedure to immediately determine a root cause and develop and implement the appropriate action plan. In the past, these plans have included one or more of the following:

1) System reconfiguration;

2) Staff overtime;
3) Workload balancing;
4) Training of personnel and providers; and
5) Hiring and training temporary workers to assist with the reduction of claim inventories.

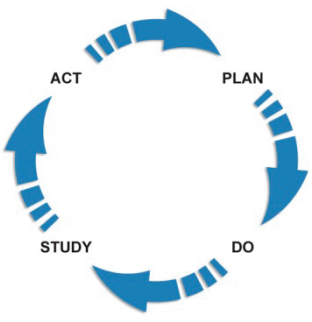
Based on our claims volume, we adjust hiring to accommodate any increased trends. Additional information on our claims monitoring and resolution of deficiencies process can be found in an illustration following our response.

***Corrective Actions Process and Resolution of Deficiencies***

When pre-payment errors are discovered during the above referenced audits, claims are pended for analysis and adjusted as required for final adjudication. If an error in adjudication of the claim indicates a system configuration problem, the issue is routed to our Business Application Management (BAM) Department for further review, analysis, testing, and correction. If adjudication errors are identified relative to manually adjudicated claims, we review/update pertinent policies and procedures and institute additional training accordingly. If our audit identifies a provider billing issue, the information is forwarded to provider services personnel for provider outreach and education as necessary.

To further support quality reviews of claims processing accuracy, a post-payment audit occurs outside the Claims Department, where stratified random samples and focused audits of paid and denied claims are overseen. The purpose of these activities is to audit compliance of claims adjudication with state regulatory requirements and provider contracts. Audit results are shared with Claims management in order to identify training and/or coaching opportunities, qualify merit-based compensation and implement corrective action as necessary.

It is our standard operating procedure to continuously monitor the adequacy of our claims adjudication process to determine its effectiveness. Aetna Better Health uses the Plan-Do-Study-Act (PDSA) model to assess our claims administration, adjudication and management processes. Our PDSA approach involves the network development and provider services units and leadership from Aetna Better Health's entire organization. The PDSA model for continuous improvement provides the framework for our approach to developing and implementing network interventions through the following steps:




1. Plan. Recognize an opportunity and plan a change.
2. Do. Test the change. Carry out a small-scale study.
3. Study. Review the test, analyze the results and identify what we've learned.
4. Act. Take action based on what we learned in the study step: If the change was ineffective, repeat cycle with a different plan. We incorporate successful interventions into our network development/management approach, using what we learned to plan new improvements, beginning the cycle again.

The leadership from Aetna Better Health's entire organization participates in the PDSA process. Supporting this process is our Service Improvement Committee, the QM/UM Committee and QMOC. Each of these committees includes cross functional and multidisciplinary leadership from across our operations. This means that member services, quality management, utilization management, grievance and appeals, and operations (e.g., claims, etc) are aware of and contribute to our claims administration planning and performance improvement activities. This organizational commitment to meeting the needs of our providers is a hallmark of Aetna Better Health success.

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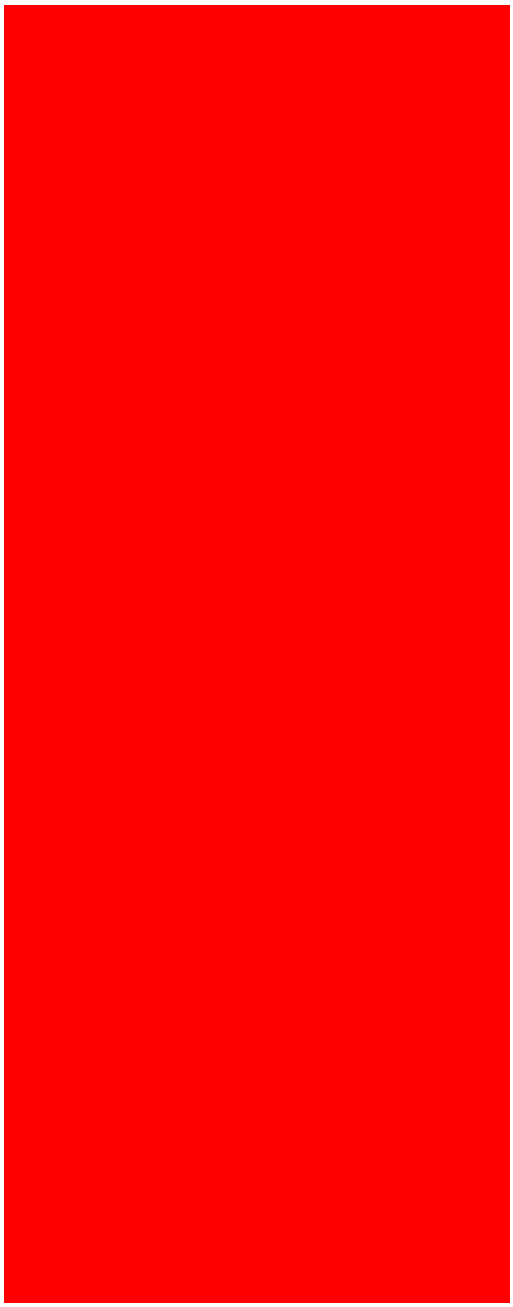

**Q.3 Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.**

## Introduction to Aetna Better Health's Claim System

Aetna Better Health along with its affiliates claims processing activities include the application of comprehensive clinical and data related edits that support the efficient, effective adjudication of claims. QNXT™, our core claims adjudication system, has data-related edits configured within its software and is supplemented by two clinical claims editing solutions. The first of the two clinical claims editing solutions, iHealth Technologies' (iHT) Integrated Claims Management Services (ICM Services), applies select payment policies from one of the industry's most comprehensive correct coding and Medical Policy content libraries. The second, McKesson's ClaimCheck®, expands upon those capabilities by enabling our claims management team to define and combine specific claims data criteria, such as provider or diagnosis, to set up unique edits that deliver enhanced auditing power.

Inbound claims are initially checked for items such as member eligibility, covered services, excessive or unusual services for gender or age (e.g. "medically unlikely"), duplication of services, prior authorization compliance, invalid procedure codes, and duplicate claims. Claims billed in excess of $50,000 are automatically pended for review, as are any requiring additional documentation (e.g. medical records) in order to determine the appropriateness of the service provided. Aetna Better Health maintains a staff of qualified, medically trained and appropriately licensed personnel – consistent with NCQA accreditation standards – whose primary duty is to assist in the determination of medical necessity. Professional claims (CMS1500s) that reach an adjudicated status of "Pay" are automatically reviewed against nationally recognized standards such as the Correct Coding Initiative (CCI), medical policy requirements (e.g., American Medical Association (AMA)), and maximum unit requirements supplied by state agencies, with recommendations applied during an automatic re-adjudication process. Other methodologies utilized throughout the auto-adjudication process include, but are not limited to, Multiple Surgical Reductions and Global Day E & M Bundling.

### *Claims Management System*

Aetna Better Health uses the QNXT™ management information system, a product of Trizetto Inc., to process Medicaid member health claims. This rules-based system allows us to set multiple edits to test claims validity, allows us to customize the edits, and to otherwise pay or deny claims in accordance with the Louisiana Department of Health and Hospitals' claims adjudication requirements. The QNXT™ edits include, but are not limited to,

- Verification of member eligibility
- Verification of covered services
- Determining whether services are within the scope of a provider's specialty
- Valid prior authorization
- Submission of required documentation
- Excessive or unusual services based on the member's age or gender

- Duplication of services
- Invalid procedure codes
- Duplicate claims

Based on one or more of these edits, unusual items result in the claim being denied or pended for further review. The system also automatically pends for further review any claims over a certain dollar amount and requires that certain codes be accompanied with supporting medical records to determine the appropriateness of the service provided.

***QNXT™ Data Edits in Support of Meeting Claims Processing Requirements***

QNXT™ has over 400 business rules that Aetna Better Health's Business Application Management (BAM) Department configures to enforce claims-related Policies and Procedures (P&Ps). The application of specific conditions, restrictions, and validation criteria promotes the accuracy of claim processing against relevant and established state standards. The edits can result in claims pending or denying depending on the editing logic. For example, if the member is not eligible on the date of service, QNXT™ will automatically deny the claim. In the event that the category of service on the provider of record does not match the procedure code billed, the claim will pend for manual review to validate accuracy of provider set-up.

Examples of data edits specific to QNXT™ include the following:

***Benefits Package Variations***

QNXT™ automatically analyzes CPT, REV, and HCPC codes to determine whether specific services are covered under the contract or benefit rules. If services are not covered, the system will automatically deny the respective claim line. The claim line will deny with the appropriate HIPAA remittance remark on the EOB.

***Data Accuracy***

QNXT™ is continually updated based on the most current code sets available (HCPCS, REV, CPT codes) by year. As new codes are added, terminated, or changed, we update the codes in QNXT™ so the system is always in compliance with HIPAA standards. If a network provider bills a code that has been terminated, QNXT™ will deny the claim line and advise the provider the code is invalid via remittance advice.

***Adherence to Prior Authorization Requirements***

QNXT™ is configured to enforce the supporting documentation requirements of certain services. In addition, QNXT™ has the ability to configure Prior Authorization (PA) by code, provider type, and place of service. QNXT™ is configured to automatically identify certain types of authorizations for medical director review. Claim edit rules are set to validate the claim against the network provider, member, dates of service, services rendered, and units authorized.

***Provider Qualifications***

QNXT™ provider files are configured by specialty and category of service. This allows for the enforcement of categories of service and provider type on claims validation. Certain procedures can only be performed by select network provider types. For example, QNXT™ will not permit the processing of a claim for in-office heart surgery by a podiatrist. iHealth lends additional support in this regard, reviewing any claim line set to "Pay" for billing appropriateness by specialty. QNXT™ checks other provider-specific items as well, verifying, for example, that each

provider has obtained the requisite National Provider Identifier (NPI) or its equivalent and included the identifier on all claims submissions.

***Member Eligibility and Enrollment***

QNXT™ validates the date of service against the member's enrollment segment to determine if the member was eligible on the date of service. If the member was not eligible on the date of service, the system will automatically deny the claim using the appropriate HIPAA approved remittance comment.

***Duplicate Billing Logic***

QNXT™ uses a robust set of edits to determine duplication of services. Examples are same member, same date, same network provider, same service, or any combination of these criteria. In addition, claim lines set to "Pay" are subjected to iHealth's duplicate logic. This logic protects against payment for services rendered by the same physician or other physicians within the same provider group

***Other Claims Processing Edits and Tools Utilized to Ensure Accuracy Throughout Adjudication Process***

**ClaimCheck® Edits**

ClaimCheck® is a comprehensive code auditing solution that supports QNXT™ by applying expert industry edits from a provider recognized knowledge base to analyze claims for accuracy and consistency with relevant P&Ps. ClaimCheck® clinical editing software identifies coding errors in the following categories:

- Procedure unbundling
- Mutually exclusive procedures
- Incidental procedures
- Medical visits, same date of service
- Bilateral and duplicate procedures
- Pre and Post-operative care
- Assistant Surgeon
- Modifier Auditing
- Medically Unlikely Services

**iHealth Edits**

Aetna Better Health also uses Integrated Claims Management Services (ICM Services), powered by *i*Health Technologies, to enhance QNXT™ edit functionality for professional claims that reach an adjudicated status of "pay". Aetna Better Health has developed algorithms with *i*Health to detect potential claims upcoding, with follow-up procedures for chart audits as appropriate. iHealth clinically edits claims to assist state agencies in promoting proper and fair payment of claims. Examples of applied edits include:

**Coding Accuracy**

If services are up-coded or unbundled, iHealth will alert the Claims Department to deny the claim line along with the specific clinical editing policy justification for the denial. The claim

line will deny with the appropriate HIPAA remittance remark on the Explanation of Benefits (EOB).

**Duplicate Billing Logic**

In addition, claim lines set to "Pay" are subjected to iHealth's duplicate logic. This logic protects against payment for services rendered by the same physician or other physicians within the same provider group

**Durable Medical Equipment (DME) Editing**

iHealth Technologies' (*i*HT) performs edits related to select DME payment policies that align with state agencies' respective covered service policies. These edits include but are not limited to, DME rentals, oxygen and oxygen systems, hospital beds and accessories, external infusion pumps and anatomic/functional modifiers required for DME services.

**Procedure Code Guidelines**

Aetna Better Health follows the AMA CPT-4 Book and CMS HCPCS Book, which provide instructions regarding code usage. *i*HT has developed these guidelines into edits. For example, if a vaccine administration code is billed without the correct vaccine/toxoid codes, we will deny the code as inappropriate coding based on industry standards. According to the AMA CPT Book, this vaccination must be reported in addition to the vaccine and toxoid code(s).

**Procedure Code Definition Policies**

*i*HT supports correct coding based on the definition or nature of a procedure code or combination of procedure codes. The ability to code in this manner supports prior authorization requirements during claim adjudication. Furthermore, these editing policies will either bundle or re-code procedures based on the appropriateness of the code selection. For example, if a provider attempts to unbundle procedures, iHT will apply editing logic that will bundle all of the procedures billed into the most appropriate code. For example, if a provider bills an office visit and also bills separately for heart monitoring with a stethoscope at the same visit, iHT will rebundle the service into the appropriate E&M or office code.

**Claims Development**

Aetna Better Health has existing policies and procedures whereby we 'develop' claims requiring additional information from a service provider or third party. Non-clean claims are pended and a letter sent to the provider indicating, at a minimum, the nature of the problem, instructions on its remedy (e.g. submission of missing documentation) and the following:

- Member name
- Provider claim number
- Patient account number or unique member identification number
- Date of service
- Total billed charges
- Coordinated Care Network's (CCN's) name; and
- The date the report was generated

Claims analysts will attempt to follow up three times within the allotted time; if a response from the provider has not been received within the allotted time, the claim is denied.

***Ensuring Adherance to Claims Processing Requirements***

**Claims Monitoring Process**

Aetna Better Health uses a suite of regularly scheduled and ad hoc reports to monitor claim receipts, production, payment, proper applicability of State mandates and quality activity on a daily, weekly and monthly basis. Sample reports include, but are not limited to, the following:

- Mail Counts and Reconciliation Reports: Used to trend receipts, plan resource allocation and verify that all claims received are accounted for in the system.
- Pended Claims Audit by Provider or Age: Includes all claims that fail auto adjudication or are suspended for manual review.
- Unfinished Claims Report: Identifies all claims by age and processing status category (e.g., open, pay, deny, pend, reverse).
- Denial Analysis: Trends denied claims with corresponding reason for the denial.
- Claims Production: Monitors daily, weekly and monthly manual and auto adjudication production.
- Claims Performance Reporting: Monitors turnaround time for clean claims over selected time periods.
- Quality Review Statistics: Reports by individual and plan as well as error frequency.

Aetna Better Health's Claims Department uses these and other reports to track specific claims and monitor workflow to see that we meet our processing standards and are compliant with DHH's standards. In addition, senior management regularly reviews claims key indicators, including claims awaiting payment and a Claims Dashboard Report. Aetna Better Health employs workflow management and comprehensive personnel training to keep claims backlogs to a minimum. Claims Supervisors also monitor daily mail receipt volumes and staffing to monitor whether we are devoting adequate resources to meet processing standards. If our reports reflect a less than favorable trend, we immediately develop and implement appropriate corrective action plans. For example, we might apply additional staffing to clear up a backlog of aged claims through a combination of overtime hours, temporary labor and workload balancing.

**Pre and Post-Payment Review**

Aetna Better Health maintains a Claims Quality Review team to monitor quality standards for all claims processes. Under the direction of the director of Operations Process and Knowledge Management (OPKM), Quality Review Analysts conduct random and focused reviews of processed claims for payment, financial and procedural accuracy. Performance is measured against established department guidelines.

Quality Review Analysts conduct a series of pre-payment audits including: 1) a one percent random sample of system-adjudicated claims, 2) a two percent random sample of all analyst-adjudicated claims, 3) a daily random sample of billed claims up to $49,999.99, and 4) 100 percent of all claims with billed charges over $50,000. When pre-payment errors are discovered during these audits, claims are pended for analysis and adjusted as required for final adjudication. If an error in adjudication of the claim indicates a system configuration problem, the issue is routed to our Business Application Management (BAM) Department for further review, analysis, testing, and correction. If adjudication errors are identified relative to manually

adjudicated claims, we review/update pertinent policies and procedures and institute additional training accordingly. If our audit identifies a provider billing issue, the information is forwarded to provider services personnel for provider outreach and education as necessary.

To further support quality reviews of claims processing accuracy, an independent (does not report to claims leadership) post-payment Audit Department is responsible for conducting stratified random samples and focused audits of paid and denied claims. The purpose of these activities is to audit compliance of claims adjudication with state regulatory requirements and provider contracts. Audit results are shared with claims management in order to identify training and/or coaching opportunities, qualify merit-based compensation and implement corrective action as necessary.

**Electronic Data Interface (EDI)**

To assist us in processing and paying claims efficiently, accurately and timely, Aetna Better Health encourages providers to submit claims electronically. To facilitate electronic claims submissions, we have developed business relationships with ten major clearinghouses, including RelayHealth, Emdeon, MedAvant, among others. We receive EDI claims directly from these clearinghouses, process them through pre-import edits to see to the validity of the data, HIPAA compliance and member enrollment and then upload them into QNXT™ each business day. Within 24 hours of file receipt, we provide production reports and control totals to all trading partners to validate successful transactions and identify errors for correction and resubmission.

**Manual Claims Acquisition (Paper)**

Providers can submit paper claims to Aetna Better Health's designated post office box. Each business day, our imaging vendor, FutureVision, retrieves, opens and sorts the mail using our pre-defined criteria for either imaging and scanning or distribution directly to Aetna Better Health. They assign each claim a unique reference number based on the date received and use it to track the claim throughout the entire adjudication process. FutureVision then converts the imaged data into an EDI ready format within 24 to 48 hours of initial receipt and forwards it to Aetna Better Health. Each business day, our IT processing personnel upload the data into QNXT™ via EDI processing. Only users with approved, secured access to claims information can view this information.

If FutureVision, for whatever reason, is unable to scan certain documents, including non-claim submissions (e.g., returned member/provider mail, explanations of benefits, checks, medical records documentation) and certain paper claims (e.g., illegible claims or poor quality printed claims), FutureVision forwards these paper documents to our Claims Administration Department, where we sort and distribute them to the appropriate department(s). We assign each claim document a unique identifying number within 24 hours of receipt and electronic store the document. We then shred the paper claims and store the electronic document in a locked and secure location prior to entering the data into QNXT™, which occurs within 2 days of receipt of the document(s) from FutureVision.

**Clear Claim Connection®**

Aetna Better Health offers network providers access to Clear Claim Connection®, a web-based, code-auditing reference tool designed to mirror how code combinations are evaluated during the auditing of professional claims. Clear Claim Connection® enables Aetna Better Health to disclose its claim auditing rules to providers, along with the clinical rationale inherent to the

system. Currently, there are approximately 2300 provider groups registered through Aetna Better Health to use this web-based tool. Providers access Clear Claim Connection® through Aetna Better Health's web portal via secure login. Various coding combinations and claim scenarios can then be entered by the provider (or his/her designated staff) to determine why, for example, a particular coding combination may result (or did result) in a denial. The provider may also review coding combinations prior to claim submission, to determine if applicable auditing rules and clinical rationale will deny the claim before it is submitted or if other supportive information is necessary on the provider's behalf, in order to promote a clean claim submission. Clear Claim Connection® databases and logic are updated regularly by Aetna Better Health for consistency with claim handling requirements, new procedure codes, current healthcare trends, and/or medical and technological advances.

The table that follows provides a mapping of claims processing methodology requirements to an explanation of Aetna Better Health's handling or policies in support of compliance.

| Requirement | Meets or Exceeds Requirement | Explanation |
|---|---|---|
| 17.2.1 Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the Enrollment Broker that applies to the period during which the charges were incurred; | Meets | Inbound claims are uploaded to QNXT™, our claims processing system, where they are subjected to multiple header and line item edits. Among these are edits that compare service data to eligibility information provided by DHH and the Enrollment Broker in order to confirm members' eligibility during the period to which charges were incurred. |
| 17.2.2 A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information: | Meets | Level I and II edits occur at the clearinghouse and handled within 5 working days. The clearinghouse bears responsibility for providing exception reports to the providers. |
| 17.2.2.1 Member name; | Meets | |
| 17.2.2.2 Provider claim number, patient account number, or unique member identification number; | Meets | |
| 17.2.2.3 Date of service; | Meets | |
| 17.2.2.4 Total billed charges; | Meets | |
| 17.2.2.5 CCN's name; and | Meets | |

| Requirement | Meets or Exceeds Requirement | Explanation |
|---|---|---|
| 17.2.2.6 The date the report was generated. | Meets | |
| 17.2.3 Medical necessity; | Meets | Clinical edits are capable of verifying when a procedure is for certain gender or an age, e.g., the claim edits will be able to detect if pregnancy-related services are inadvertently being assigned to a male member. Refer to 17.2.4 applies edits accordingly. |
| 17.2.4 Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the CCN granted such approval; | Meets | Aetna Better Health's Business Application Management (BAM) Department is responsible for the accurate and efficient configuration of functional business requirements and rules within QNXT™ necessary for administrative services to occur. This includes meeting claims processing standards and auto-adjudication targets. The objectives of the build are to:<br>• Analyze business requirements to design and configure an optimal and efficient system build that will minimize the need for manual processing.<br>• Load the rules and requirements of a new health plan, product or business function in the claims processing system, including eligibility file layout, provider contracts, fee schedules and member benefits and prior authorization requirements.<br>• Complete configuration documentation while entering the build information.<br>• Audit and validate the build based on the rules and requirements stated by the health plan and the implementation team.<br>• Jointly perform unit testing with the Operations Process Knowledge Management (OPKM) Testing team to validate that the system is operational and meets business requirements.<br>• Participate in end-to-end testing with all impacted departments to see that the system is operating as expected. |
| 17.2.5 Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed; | Meets | |
| 17.2.6 Covered Services - See that the system verifies that a service is a covered service and is eligible for payment; | Meets | |
| 17.2.7 Provider Validation - See that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted; | Meets | |
| 17.2.8 Quantity of Service - See that the system shall evaluate claims for services provided to members to see that any applicable benefit limits are applied; | Meets | |
| 17.2.9 Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span; | Meets | |

| Requirement | Meets or Exceeds Requirement | Explanation |
|---|---|---|
| 17.2.10 Perform post-payment review on a sample of claims to see that services provided were medically necessary; and | Meets | Aetna Better Health maintains an independent (i.e. does not report to claims leadership) post-payment Audit Department responsible for drawing stratified random samples and conducting focused audits of paid and denied claims. The purpose of these activities is to audit compliance of claims adjudication with DHH regulatory requirements and provider contracts. Audit findings are shared with Claims management for root cause analysis and corrective action. |
| 17.2.11 Have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity. | Meets | |
| **17.3 Explanation of Benefits (EOBs)** | | |
| 17.3.1 The CCN shall within forty-five (45) days of payment of claims, provide individual notices to a sample group of the members who received services. The required notice must specify: | Aetna Better Health acknowledges and will comply. All elements required in the Explanation of Benefits will be included in the EOB provided to CCN members. As new EOB requirements and elements are updated, Aetna Better Health will comply and as such, make necessary modifications to existing EOB reported fields as required. | |
| 17.3.1.1.1 The service furnished; | | |
| 17.3.1.1.2 The name of the provider furnishing the service; | | |
| 17.3.1.1.3 The date on which the service was furnished; and | | |
| 17.3.1.1.4 The amount of the payment made for the service. | | |
| 17.3.2 The CCN shall also: | | |
| 17.3.2.1 Include in the sample, claims for services with hard benefit limits, denied claims with member responsibility, and paid claims (excluding ancillary and anesthesia services). | | |
| 17.3.2.2 Stratify paid claims sample to see that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the CCN considers a particular specialty (or provider) to warrant closer scrutiny, the CCN may over sample the group. The paid claims sample should be a minimum of two hundred (200) to two hundred-fifty (250) claims per year. | | |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| 17.3.3 The CCN shall track any complaints received from members and resolve the complaints according to its established policies and procedures. The resolution may be member education, provider education, or referral to DHH. The CCN shall use the feedback received to modify or enhance the EOB sampling methodology. | Meets | Aetna Better Health maintains an internal, proprietary application that supports the Grievance and Appeals process by tracking member and provider issues from inception to resolution. This affords us the means to address not only issues affecting individual member and provider satisfaction, but potential trends in the delivery system as a whole, permitting health plan personnel to take prompt, corrective steps to minimizing risks to performance standards. Feedback received during this process or feedback received through other means, will be shared with the appropriate personnel within the Claims unit for future handling and modifications in concert with the IT Department. |
| 17.4.1 Each remittance advice generated by the CCN to a provider shall, if known at that time, clearly identify for each claim, the following information: | Meets | QNXT™, Aetna Better Health's core transaction processing system, generates paper Remittance Advices (RAs) for our providers. In addition, providers taking advantage of our Electronic Fund Transfer (EFT) capability have the option of receiving Electronic Remittance Advices (ERAs). Business Application Management (BAM) personnel configure QNXT™ to generate RAs formatted such that required data elements are readily identifiable. |
| 17.4.1.1 The name of the member; | Meets | |
| 17.4.1.2 Unique member identification number; | Meets | |
| 17.4.1.3 Patient claim number or patient account number; | Meets | |
| 17.4.1.4 Date of service; | Meets | |
| 17.4.1.5 Total provider charges; | Meets | |
| 17.4.1.6 Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount; | Meets | |
| 17.4.1.7 Amount paid by the CCN; | Meets | |
| 17.4.1.8 Amount denied and the reason for denial; and | Meets | |
| The following statement shall be included on each remittance advice sent to providers: “I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under | Meets | Aetna Better Health’s existing remittance advice can be configured to meet this requirement. |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| applicable federal and/or state laws." | | |
| 17.5.1.1 The CCN shall see that ninety percent (90%) of all clean claims for payment of services delivered to a member are paid by the CCN to the provider within fifteen (15) business days of the receipt of such claims. | Aetna Better Health presently manages its claims payment process such that State mandated payment timeframes are either met or exceeded by the Claim's Unit. For example, in Florida, Aetna Better Health manages the claim process such that the entire claims process is completed with 12 days on average, with an added 7 days tagged on to the process to account for check issuance purposes, so that the total time to process, on average is 20 business days (the requirement is 20 days), thus the claim payment time exceeds the mandatory timeframe in Florida. Aetna Better Health anticipates also exceeding the expectations of the Louisiana Department of Health and Hospitals, which provide for payment of 90% of clean claims within fifteen days and 99% payment within the allotted thirty calendar day timeframe. | |
| 17.5.1.2 The CCN shall process and, if appropriate, pay within thirty (30) calendar days, ninety-nine percent (99%) of all clean claims to providers for covered services delivered to a member. | | |
| 17.5.1.3 If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing. | Meets | When an otherwise claim denies specifically on the basis of lack of documentation required to process the claim, the remittance advice identifies with specificity the reason for the denial. Providers are instructed to resubmit the claim, along with the required document and to notate that the claim is a resubmission. As such, those claims with the "resubmission" notation receive are adjudicated for timely filing using the original submission date of the claim. |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| 17.5.1.4 To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than:<br>• The time period specified in the provider contract between the provider and the CCN, or if a time period is not specified in the contract:<br>– The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or<br>– If the CCN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH. | Meets | Aetna Better Health capitated contracts provide for payment by the 15th calendar day of the month. Network providers indicate their agreement with this timeframe as evidenced by their signing the agreement and the specific provider rate attachment. |
| 17.5.1.5 The CCN shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim. | Meets | Aetna Better Health acknowledges and will comply. Aetna Better Health acknowledges DHH's timely failing related to subrogated or COB claims and will comply with said requirements. It is Aetna Better Health's standard operating procedure to accept claims that are within the statutorily allotted timely filing limits, and those timeframes and other considerations applicable to subrogated claims or coordination of benefits |
| 17.5.1.6 The CCN shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH. | Meets | As part of our credentialing process, Aetna Better Health queries the listing of excluded individuals, pursuant to the requirements of section 1128 or 1156 of the Social Security Act, and sees that those providers treating members covered under the agreement between Aetna Better Health and the DHH, are in good standing with DHH prior to completing the contracting and credentialing process. At recredentialing, the procedures are followed to make certain good standing with DHH and lack of exclusion or restriction for participation in a Medicaid, Medicare or other government healthcare program. Aetna Better Health, through |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| | | its vendor PDS, also conducts queries of non-network providers, on a periodic and random basis, to supplement its existing query processes related to the contracted network. |
| **17.5.2 Claims Dispute Management** | | |
| 17.5.2.1 The CCN shall have an internal claims dispute procedure that shall be submitted to DHH within thirty (30) days of the date the Contract is signed by the CCN, which will be reviewed and approved by DHH. | Meets | Aetna Better Health's Claims Administration Department employs full-time claims inquiry and Research Representatives to respond to provider questions, status inquiries and claims payment disputes via the claims inquiry line from 8:00 a.m. to 5:00 p.m., Monday through Friday. An automated telephone system allows callers to speak directly with a Representative or leave a detailed message regarding their inquiry.<br><br>Whenever possible, the provider inquiry will be resolved while the provider is on the phone. If the provider's inquiry cannot be resolved while the provider is on the phone and the provider's inquiry requires additional research to reach resolution, then a call tracking case will be open for the provider's issue. It is the department's goal to research and respond to the provider's issues within five to ten business days. When it is not possible to resolve the issue within this time frame, then the issue will be call tracked to the appropriate department, and thereafter followed by an independent reviewer. Claim disputes may escalate, at the request of the provider, to the Grievance and Appeals process. As such time, established Grievance and Appeals procedures are followed and applied to the provider's claim dispute.<br><br>Aetna Better Health acknowledges and will comply with the requirement to submit its specific claims dispute policies to the DHH within 30 days of contract award.<br><br>Claim dispute data is captured by Aetna Better Health in its systems and further documented through the Grievance and Appeals process, as applicable. |
| 17.5.2.2 The CCN shall contract with independent reviewers to review disputed claims. | Meets | |
| 17.5.2.3 The CCN shall systematically capture the status and resolution of all claim disputes as well as all associated documentation. | Meets | |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| **17.5.3 Claims Payment Accuracy Report** | | |
| 17.5.3.1 On a monthly basis, the CCN shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the CCN. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission. | Exceeds | Aetna Better Health maintains a Claims Quality Review Team to monitor quality standards for all claims processes. Under the direction of the director of Operations Process and Knowledge Management (OPKM), Quality Review Analysts conduct random and focused reviews of processed claims for payment, financial and procedural accuracy and provider inquiry calls, which focus on both accuracy and customer service skills. Performance is measured against established department guidelines.<br><br>Moreover, the Claims Quality Review Team fully audits the work of all new claims analysts for at least one month subsequent to their orientation and training. The audit starts at 100 percent of their work product and decreases to a standard two percent by the fifth week, provided the new claims analyst continues to meet claims accuracy standards. Finally, we review 16 provider calls per Claims Inquiry Representative per month, assessing the quality of service interaction and accuracy of information provided. Individual quality reports are presented to the Representative and their Supervisor for corrective action (e.g., live call monitoring) if appropriate.<br><br>Quality Review Analysts conduct a series of pre-payment audits including:<br><br>1) A one percent random sample of system-adjudicated claims,<br><br>2) A two percent random sample of all analyst-adjudicated claims,<br><br>3) A daily random sample of billed claims up to $49,999.99, and<br><br>4) 100 percent of all claims with billed charges over $50,000.<br><br>We will have one full time Auditor assigned and we will pull a total of 4 audits per month; two UB (facility) files and two 1500 (physician) files based on a two week paid date/check cycle. Our sample size is 95/2/2 (95% confidence; the error rate is |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| | | 2%; with a desired precision of +/- 2%) which is an average of 180+ claims reviewed each week. Each file provides Aetna Better Health with Payment and Financial Accuracy findings for the period audited and each file is distributed for review and response to all applicable departments. |
| 17.5.3.2 The minimum attributes to be tested for each claim selected shall include:<br>• Claim data correctly entered into the claims processing system;<br>• Claim is associated with the correct provider;<br>• Proper authorization was obtained for the service;<br>• Member eligibility at processing date correctly applied;<br>• Allowed payment amount agrees with contracted rate;<br>• Duplicate payment of the same claim has not occurred;<br>• Denial reason applied appropriately;<br>• Co-payment application considered and applied, if applicable;<br>• Effect of modifier codes correctly applied; and<br>• Proper coding. | Exceeds | Post-payment audits review, at a minimum, include audit for the attributes listed in requirement 17.5.3.2., and also provide for review of:<br>• Coding, e.g. proper use of codes and modifier codes;<br>• Member eligibility;<br>• Data entry into the systems is accurate;<br>• Timely Filing;<br>• Claim is associated with the correct treating provider;<br>• Prior Authorization requirements;<br>• Denial reasons applied correctly;<br>• Benefit application (including limitations and exclusions);<br>• Coordination of Benefits application;<br>• Claims history review for duplicate claim;<br>• Manual Pricing application;<br>• Contracted Provider and Special Provider agreements, such as one-time case agreements and for both ensuring payment amount agrees with contracted rate;<br>• Modifier Discounts; and<br>• Claims bundling/unbundling.<br>• Contracted Provider and Special Provider agreements, such as one-time case agreements and for both ensuring payment amount agrees |

| Requirement | Meets or Exceeds Requirement | Explanation |
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| | | with contracted rate;<br>• Modifier Discounts; and<br>• Claims bundling/unbundling |
| 17.5.3.3 The results of testing at a minimum should be documented to include:<br>• Results for each attribute tested for each claim selected;<br>• Amount of overpayment or underpayment for each claim processed or paid in error;<br>• Explanation of the erroneous processing for each claim processed or paid in error;<br>• Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and<br>• Claims processed or paid in error have been corrected. | Exceeds | Audit documentation comprises, at a minimum, documentation of findings by attribute, the amount of the associated under/overpayment, the root cause and resolution status. Audit files remain 'open' until all identified issues have been resolved and corrections/adjustments implemented accordingly. |
| 17.5.3.4 If the CCN contracted for the provision of any covered services, and the CCN's contractor is responsible for processing claims, then the CCN shall submit a claims payment accuracy percentage report for the claims processed by the contractor. | Exceeds | Delegated vendors are required to match Aetna Better Health's Claims auditing procedures. To monitor compliance with this contractual requirement, Aetna Better Health conducts a semi-annual and annual evaluation of delegated vendor claims auditing processes, and we will include a review of DHH specific audit requirements as part of our delegation oversight process. |
| **17.5.5 Claims Summary Report** | | |
| 17.5.5.1 The CCN must submit quarterly, Claims Summary Reports to DHH by GSA and by claim type. | Meets | Aetna Better Health acknowledges and will comply. |